

MODERN ABNORMAL PSYCHOLOGY

Edited by
W. H. MIKESELL



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A Symposium

Edited by
W. H. MIKESELL

Bureau Ednl. Psy. Research
DAVID HARE TRAINING COLLEGE

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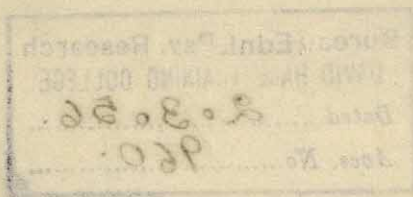
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CONTRIBUTORS

- JOHN R. ADAMS, M.D., Department of Adult Psychiatry, Menninger Foundation, Topeka, Kansas.
- JOHN ARSENIAN, Ph.D., Psychologist, Boston State Hospital, Dorchester Center, Mass.
- JOHN H. BAIRD, M.D., Associate in Clinical Psychiatry, Georgetown University Medical School, Washington, D. C.
- NORMAN Q. BRILL, M.D., Professor of Neurology, Georgetown University Medical School, Washington, D. C.
- RALPH R. BROWN, Ph.D., Psychologist, United Industrial Service, Cincinnati, Ohio.
- PETER D. FLEMING, M.D., Psychiatrist, Winter Veteran's Administration Hospital, Topeka, Kansas.
- SIGMUND GABE, M.D., Los Angeles, California.
- HEINZ M. GRAUMANN, Ph.D., Psychologist, Topeka State Hospital, Topeka, Kans.
- MARTIN GROTJAHN, M.D., Los Angeles, California.
- SIGMUND GUNDLE, M.D., University of Kansas, Lawrence, Kansas.
- GORDON C. HANSON, Ph.D., Psychologist, Municipal University of Wichita, Wichita, Kansas.
- GLENN D. HIGGINSON, Ph.D., Psychologist, University of Illinois, Urbana, Illinois.
- EDWARD W. LAZELL, M.D., Psychiatrist, Veteran's Administration, Denver, Colorado.
- JOHN M. LYON, M.D., University of Colorado Medical Center, Denver, Colorado.
- WILLIAM H. MIKESELL, Ph.D., (Editor-in-Chief), Chairman of Psychology Department, Washburn University, Topeka, Kansas.
- SAMUEL PASTER, M.D., Psychiatrist, Chief Neuropsychiatric Service, Kennedy Veteran's Administration Hospital, Memphis, Tennessee.
- LILLIAN G. PORTENIER, Ph.D., Psychologist, University of Wyoming, Laramie, Wyoming.

HARRIET P. RAY, M.A., Psychologist, Chicago, Illinois.

DONALD A. ROTHSCHILD, Ph.D., Psychologist, Eastern Illinois State College, Charleston, Illinois.

MILTON R. SAPIRSTEIN, M.D., Psychiatrist, Psychoanalytic Clinic for Training and Research, Dept. of Psychiatry, Columbia University, N. Y.

EMILY L. STOGDILL, Ph.D., Psychologist, Ohio State University, Columbus, Ohio.

LEO V. TEPLEY, M.D., Psychiatrist, Republic Building, Denver, Colorado.

GREGORY ZILBOORG, M.D., Psychiatrist, 33 East 70th St., New York, N. Y.

ALBERT C. VOTH, Ph.D., Psychologist, Clarinda State Hospital, Clarinda, Iowa.

HOWARD R. WHITE, Ph.D., Chief Clinical Psychologist, Veteran's Administration Medical Teaching Group, Kennedy Hospital, Memphis, Tenn.

MODERN
ABNORMAL PSYCHOLOGY

**Definitions — History of Mental Diseases — Dynamics of
Maladjustment and Adjustment**

ABNORMAL IN BEHAVIOR

By
WILLIAM C. HANSON, Ph.D., Psychologist

University of Wichita, Wichita, Kansas

Psychotic — History of Mental Disease — Dynamics of
Maladjustment and Adjustment

Chapter 1



THE NORMAL AND ABNORMAL IN BEHAVIOR

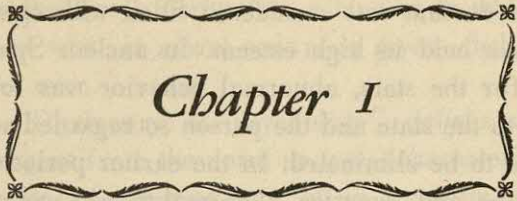
By

GORDON C. HANSON, Ph.D., Psychologist
Municipal University of Wichita, Wichita, Kansas



THE
NORMAL AND
ABNORMAL IN BEHAVIOR

GEORGE C. HAYSON, Ph.D., Psychologist
University of Illinois at Chicago



Chapter I

THE NORMAL AND ABNORMAL IN BEHAVIOR

By GORDON C. HANSON, Ph.D., Psychologist
Municipal University of Wichita, Wichita, Kansas

I. Introduction-Interest in the Bizarre and Place of Abnormal in Various Cultures

Since the dawn of known history man has been interested in the unusual, the grotesque, and the bizarre. That which is commonplace does not attract his attention as much as that which is deviant. He tends to have a morbid curiosity about anything that is related to mental abnormality and in particular to what he formerly called "insanity." The sideshows in the circus are filled with human curios whose only attraction is a radical departure in some significant trait from the average of the population. Every hamlet has its own "character" whose unusual characteristics rest on his behavior varying from that of the group to a significant degree. Man is made aware of the unusual more than the usual behavior of the average person on the street. Normal behavior is accepted without question or comment.

The place that abnormal behavior has had in culture at various times is an interesting commentary on how people have looked upon deviation in different parts of the world at different times. In the Middle Ages the court fool was an entertainer and his services were in demand to add amusement to an otherwise dull monotonous life. Among some of our native tribes in Amer-

ica the mental deviant was considered filled with spirits; consequently, he was held in high esteem. In ancient Sparta, where man existed for the state, abnormal behavior was looked upon as dangerous to the state and the person so regarded was a parasite that ought to be eliminated. In the earlier period of Christianity in Europe and America abnormality was connected with the devil and the only thing that could be done with an obsessed person was to beat "the devil out of him." When we think of all the poor people in the western world who were literally beaten to death for being feeble-minded, dull, or psychologically maladjusted, we begin to recognize how significant the attitude of the time towards abnormality may be for any person regarded as abnormal. It is not so long ago that in institutions in America flogging and straight-jackets were used in dealing with the insane people. And there are still remnants in American culture suggesting that people are handicapped because they are paying for the sins of their forefathers unto "the third and fourth generations."

II. Various Definitions of the Term

What do we mean by "normal" and "abnormal"? Perhaps the best approach to answering that question is to examine a few definitions from current books in the field. At best definitions are rather vague and incomplete. From the few samples cited below we note that there are several factors emphasized in each definition, namely, divergent behavior, group evaluation of that behavior, and social effectiveness. No short description can include all the variables and relative values involved in the complex behavior of man, whether it is normal or abnormal. To understand the problem, due recognition must be given to different orientations and thus to the different interpretations of behavior.

The word "abnormal" is derived from the Greek word "anomalos" meaning irregular; from "an—not" and "omalos—

even." From the Greek derivatives a clue as to what was meant originally and what is meant today, is given—behavior that is irregular, not even.

Warren's "Dictionary of Psychology" defines abnormal as "widely divergent from the norm or type (characterizing actions, mentality, modes of behavior, etc., of an organism, which differs so much from the average, sane, healthy, or typical that they are not treated as belonging to the same group or series)."

Cameron, in "The Psychology of Behavior Disorders," speaks of personality as abnormal "if at any age an individual who was otherwise in good health grew seriously or progressively ineffectual as a social person."¹

V. E. Fisher in his "Introduction to Abnormal Psychology" describes the normal person as "one who lives at least a moderately independent and industrious life and who at the same time gets along with his fellow men sufficiently well to keep himself out of mental hospitals, jails, and feeble-minded institutions."²

Edmund S. Conklin in "Principles of Abnormal Psychology" defines abnormal psychology as the study of those "forms of human behavior which differ sufficiently from those which are commonly accepted as normal to be recognized as different, irregular, or disordered."³

Tiffin, Knight, and Asher in "The Psychology of Normal People" state that abnormal psychology "deals with individuals who have in some respects deviated markedly from the norm or average. In the normal person there is a blend of many interests and activities, so that no single aspect of the individual stands out in isolation. In the abnormal person this blending or integration of interests is broken down, with the result that a particular interest or activity stands out clearly."⁴

A. Subjective Basis for Determining Abnormality

Everyone is familiar with the saying supposed to have been

uttered by a Quaker to his wife, "Everyone is queer save me and thee and sometimes thee is a bit queer too." In everyday living we judge people in terms of how they fit into the current pattern of life largely by using our own measuring rods—ourselves or the people with whom we associate. People are queer when they deviate from our particular behavior in any particular situation. The man who has a foreign brogue and dresses in a foreign way is peculiar and we do not understand him. The woman who smokes a clay pipe instead of cigarettes is considered uncouth. The mother who nurses her child whenever it is hungry and wants food is a peculiar specimen who likely lacks "the brains to read the baby manuals, else she would know that babies are only fed at six, ten, two, six and ten." The man who keeps his money under the mattress or in a sock under the bed instead of in the bank is not normal and "it serves the old miser right if he loses everything he has." The man who sleeps too long or too little is peculiar. Social custom sets the pattern in the community. In one place to be normal a man gets up at five and goes to bed at ten; in another place, he never goes to bed before midnight and he gets up some time before lunch. The person who goes to bed at nine in the latter society is labelled queer, while in the former the person who gets up at eleven is a "bit off" and the neighbors are certain that he needs watching. To the Puritan lady of the early colonial period the modern Jitterbug would be quite abnormal and bedeviled. It is readily seen that we tend to use ourselves and our social customs as the reference points in all our evaluations.

The trouble with the subjective point of view is that normality is determined by the person doing the judging. A person's entire experience in a particular social setting is behind the decisions that are made—his opinions, his prejudices, his desires, his halos, his physical health, in short, all his development thus far. If a man behaves so that we like him, and what he does is not

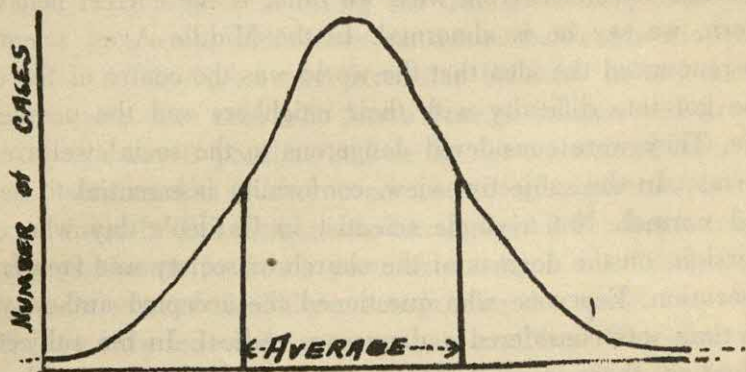
in violation of our code for approved behavior in that kind of situation, he is designated as normal. If he antagonizes us by doing some things that frustrate us and belittle us and if he seems to deviate too much from what we think is the correct behavior pattern, we say he is abnormal. In the Middle Ages, scientists who renounced the idea that the world was the centre of the universe got into difficulty with their neighbors and the people at large. They were considered dangerous to the social welfare of the state. In the subjective view, conformity is essential to being rated normal. Not a single scientist in Galileo's day who cast aspersions on the dogmas of the church or society was free from persecution. Everyone who questioned the accepted authority at that time was considered a dangerous radical. In the subjective evaluation, there is no standard except that set down by the individual who passes judgment. Naturally there will be as many different decisions as there are persons judging.⁵

B. Abnormality from the Viewpoint of Statistics

From the viewpoint of statistics the normal person is he who seems to behave in the regular fashion peculiar to the person falling in the statistical average of the group, the one who is like most of the other people in his behavior.

In the latter part of the nineteenth century we began using mathematics extensively in all our scientific research in psychology. It began to be a powerful tool when we gained the statistical concept of the normal probability curve. Statisticians found that biological, psychological, and social data, when properly treated, fell into an orderly system. If a large number of people were used and the selection were a random sampling, the distribution would likely be on the normal distribution curve, which was bell-shaped. The mass of persons were found clustering close to the middle with the numbers decreasing as the distance from the middle increased. It was a natural reaction to

say that normal should be equated with the usual and abnormal with the deviations from the average. At first the statistical approach seemed to have solved most of our problems.



It is readily recognized that the curve did not solve all problems in psychology. How far out should we go from the middle before we would be considered deviates above or below the average range? Would we find the same kind of curve in every kind of measurement in every kind of society? Would all traits distribute themselves on the curve in the same way?

1. The Statistical Norm Does Not Solve Adjustment

About the time of the First World War we accepted Thorndike's idea that if a thing existed, it existed in quantity and could be measured.⁶ The assumption was made that all people have the same traits but that they vary in degree. Most people fall into the average range, and as we go out from the statistical average, we have fewer and fewer people. In the case of intellectual development, all people would be found on the scale from zero up to the top of the range. The man on the street considers below average as inferior and above average as superior. But this is not necessarily true. All-round adjustment is in terms of group adjustment. He is best adjusted whose traits fit in with the

group pattern. But adjustment is not on the basis of a single trait. In some traits he may be higher or lower than average but no single trait could ever be considered an absolute criterion. Adjustment is in terms of relationships. Quantitative measurements of any single trait, good as they are, usually are not adequate for judging normality in behavior.

In thinking of the behavioral disorders in which abnormal psychology is interested, we recognize certain difficulties. All people have acute problems in adjustment at times. Scarcely any deficiency can be mentioned that each of us has not exhibited in degree at some time or other. In terms of statistics, our deviation was so slight and for so short a time that the behavior was normal. The dullard who is low on the curve for school work may be quite efficient on the football field where his learning is superior. He may be quite skilled in mechanics. Low or high ratings in one area cannot be inferred necessarily to mean low or high ratings in another trait or skill. It is the diversity of traits that make for individual differences. Human beings tend to adapt on many social levels and the traits that tend to operate in one level for normality may in another be considered abnormal. Statistical studies are cross-sectional and at best get only a sampling of behavior.

Much of today's thinking is influenced by the statistical concept. We judge a man to be normal if he falls within the normal range statistically. The dividing line is arbitrary between normal and abnormal. If in height the average American male adult is five feet eight inches and a person deviates beyond the normal range, he is abnormal. The criterion for normal behavior should not be a statistic in terms of height but rather where under-size or oversize impairs efficiency. Many a man five feet tall is well adjusted just as many a man five feet eight inches tall is maladjusted. No single criterion is enough to explain personal adjustment. If, however, a large number of measurements are

made and the same trend is found in all of them the findings may be statistically significant. But in every case relationships must be recognized for an understanding of behavior.

In utilizing the results from the measurement of intelligence we use the statistical approach. The average range of intelligence is from .90 to 1.00 I.Q. Below .90 is dull and feeble-minded; above 1.10 bright and genius. It is popularly thought that the below average people are abnormal. But the fact remains that in a simple rural society most of the people well below .90 I.Q. could adjust satisfactorily. However, in an industrial, mechanized, urban society with all its complexity, some of them find adjustment difficult. So would most of us in a society of Einsteins! If averages are to be used in talking about normality they must be used in relation to the group directly involved and then they must be cautiously interpreted. To pass any judgment on the basis of intelligence involves a knowledge of the situation and the kinds of adjustments that must be made. In our industrial studies we tend to set the minimum and maximum intelligence scores for particular jobs, basing the range on what has been found in that particular situation the best for long range satisfactory performance on the job. It is merely a case of matching men to particular jobs using intelligence as one criterion. If we disregard the intellectual factor we tend to have inefficient workers and potential trouble-makers. Normal in this kind of situation means adjusted to the job and a factor in the process is intelligence.⁷

2. Where Does the Normal Range End?

Where does the normal range end and the abnormal begin? That is a question that no one can answer, not even a statistician. There is no scientific reason for setting the I.Q. average range between .90 and 1.10. As stated before the division is purely arbitrary. We do not have any accurate statistical measuring

rods with which to measure normality. This is seen when we deal with something like criminal behavior. It is common to hear "There ought to be a law—." But all crimes are not of the same degree of infringement of statute law, nor are all wrongs crimes. Obviously not all the little things that each of us do which does not fit into the social pattern are punishable as crime. Some acts are even so trivial that they do not warrant any public attention. Many wrongs are purely personal and not significant enough to be worth the interest of law as such. Crimes, then, are only those illegal acts, or perhaps failure to act, which violate a public right and are punishable under the law. Crimes may be almost any acts of commission or omission. But such definitions do not set the limits to the abnormal behavior that we call criminality. Many illegal acts can straddle fixed boundaries. The criminal label is more dependent upon viewpoint and current interest than upon any form of logic or set of statistics. Crime is a legal concept and can be understood in only time and place. The death penalty was prescribed in colonial Massachusetts for children above sixteen guilty of "smiting or cursing their parents." Severe punishment was meted out for sledding on Sunday morning. In Sparta confirmed bachelors were publicly scourged and humiliated. In most of our states prostitution is a criminal offense but not so in France. Many acts which deviate markedly from the common accepted forms of behavior, acts which are shocking, immoral, and degrading to society can be punished as criminal. No statistic can determine where the wrong is grave enough to be criminal, nor can anyone say statistically where one's behavior as a normal person is sufficiently adjusted in time and place to be called normal. As in all behavior, criminal behavior is related to a large number of contributing factors involved in the adjustment process. All the causative factors are relative. Normality depends upon the person, the situation, the society and not upon any statistical scale.

C. The Physiological or Developmental Aspect

Abnormal psychology may be considered from the physiological or development aspect. When a child deviates too much in growth, above or below the average of his group, he may be looked upon as abnormal in that particular development. The underlying cause or causes may be malfunctioning glands, or deficient diet, or serious emotional disturbance, or any one of a number of factors contributing to the malfunctioning condition. What is known as gigantism is caused by a glandular disturbance, and from the viewpoint of size, the giant is a deviant. Because of other people's reaction to him he may be peculiar in his behavior and a misfit in society. But the same may be said of the dwarf who has somewhat the same problem in reverse. He finds it difficult to fit into the social group of which he is a part. In the case of basal metabolism which deals with the rate of energy production in the body, the large majority of people have metabolic rates at about zero. Only a few deviate a great deal from it. If the deviation is above plus ten or below minus ten the person is considered abnormal in his metabolism. We speak of blood pressure as abnormally high or abnormally low. To the extent that it deviates from the average for that particular age group do we feel that it is serious. We speak about normal vision, normal hearing, normal reaction time when what we are talking about fits into the pattern of the usual performance for that age group.

Much of our problem of abnormality with "exceptional children" hinges on deficiency in development or malfunctioning of some organ or system vital to normal growth, as in the case of blindness, deafness, energy deficiency, anemia, etc. Exceptional children find adjustment difficult because usually they are handicapped both in learning and in behaving as the average member of society behaves. Certainly the spastic child finds learning difficult when he cannot talk, or move his arms or legs,

or perhaps is unable to keep control of any part of his complex. The blind child fails to get impressions through seeing and misses the learning involved from those impressions. The deaf child is shut out from the world of sound. The speech handicapped child is unable to have normal communication with the people in his environment, thus he finds socialization quite difficult.⁸

Whenever the child or adult has difficulty through some failure in proper body development, or the failure of some essential system in the organism, or some failure in the organization of the body chemistry through malfunctioning organs, or perhaps through deficiencies in diet—whatever the cause—there is a serious problem of adjustment. In psychology we are largely concerned with the problem of behavior. Where there are serious deficiencies in the organism which limits a person in exploring his environment or reacting to his environment it is easy to get unusual or variant reactions. Where the organism as such functions in complete harmony the behavior is more likely to be average or normal. In terms of performance in a competitive society, the handicapped person is usually on the low end of the scale. If he has eye difficulty, he is likely to be a poorer than average reader, his learning is deficient, his relations with people are not too good, he has strong feelings of inferiority, he may be ridiculed by his fellows and called uncomplimentary names.

Since we have interpersonal relations to consider in a social world, whatever affects those relations negatively will be involved in the adjustment process. Every handicapped person usually has personal problems which he finds impossible to solve in a socially acceptable way. But the most difficult one is that hinging on human relations. It is here that any defect becomes most significant. How people react towards a handicapped person who has a serious defect is always crucial in his life. To a great extent abnormal behavior depends on personal interaction: how A reacts to B in part depends upon how B reacts in turn to

A. It is readily seen that the handicapped person starts out with two strikes against him because he cannot do adequately what normal people do and his behavior is called abnormal by the people who have group norms by which to judge.

D. The Social Viewpoint

From the social viewpoint a person is abnormal when, as a social being, he is unable to participate effectively in the social activities which, as a member of society, are incumbent upon him. He must learn the content of cultural transmission. When we consider a person as a social creature living in a social world the problem of abnormality is gauged on degrees of maladjustment to his society. He who has learned how to live in a satisfactory manner with his peers is rated by them as normal. If he varies in conduct too radically and too often he is soon labeled "Queer", "Goofy" or "Daft"—that is, he is abnormal. From the social viewpoint in a democracy, man must adjust to his social environment by behaving in conformity with the will of the majority. Of necessity he must conform with what has been transmitted from generation to generation. It is essential that a man learns how to behave as a member of society in his home, towards his family, towards his relatives, toward his neighbors. To be adjusted he learns how to eat, how to clothe himself, how to conduct himself in his everyday relations with men and women; he learns their value system and their habits of thought. In brief, he has to learn all of the culture that is regarded as necessary to adequately live with people. He has to conform to the pattern of society as he finds it in time and place. He is normal, too, when he can learn the cultural accretions as they come without too much effort and conflict. Lack of tact, rudeness, unsociability, and lack of poise are samples of a degree of failure in social learning. Being socially adequate is a life-long process of achievement. Few people really recognize how

involved the learning of social customs becomes in a complex society.

E. The Ethical Point of View

From the ethical point of view the person is abnormal who varies from the approved norm in his behavior regarding values dealing with right and wrong. In the way he thinks and acts, the deviant does not conform to the standard of ethical values as set up by society or some group in society. When the writer was a boy, a socialist was considered a sort of depraved human being whose sense of values was distorted and dangerous. He was a person who could not be trusted. Not only would he rob the naive person of his religion but he might go so far as to murder a man to get his sinister ideas across. Many a socialist was considered abnormal because he differed from the average regarding social rights and wrongs, because he placed certain social values above personal gain and rugged individualism.

In a community where a particular kind of religion dominates, a man who differs is considered queer. In most communities the Seventh Day Adventist is a freak. He works on Sunday and rests on Saturday—that alone would put him in an unfavorable position on the current value scale. To many people he is ungodly and desecrates Sunday.

In examining different culture patterns as Margaret Mead and Malinowski have done, it is seen that right and wrong are relative to what is done by the people.⁹ Cultural change is slow. What is handed down is right regardless of what outsiders think. In his "Sex and Repression in Savage Society," Malinowski gives numerous incidents which show the place of sex in that particular group setting. Based on our standards of right and wrong, some of the sex behavior of these primitive people would be considered perverted. From their viewpoint, some of our behavior would be both vicious and dangerous.

Even in western civilization there is a radical difference in what is considered right regarding almost any moral value common to society. Certainly it is true with reference to marriage, child rearing, mating, recreation, religion, and politics. In Mexico, bull fighting is approved and gets equally as much publicity as a World Series, a championship prize fight or a Democratic Convention in our country. We say bull fighting is immoral and people who engage in it are abnormal. Sponsoring lotteries by the government is legitimate in Ireland; in America it is criminal regardless of who is behind the gambling. In America a man has no right to beat his wife; in most oriental countries a man would be delinquent if he refrained from performing his duty if a beating was considered necessary. Among the Eskimos, the Tahitians, and the Melanesians children are subject to little or no discipline. According to their way of thinking about the social structure, that is the right way to rear children. Using white man's discipline on these children would be considered degrading and he who would punish a child would be ostracized from society as a disreputable wretch.

It is seen from anthropological studies that what is right in one place is wrong in another. A person is normal in behavior in one society, yet with the same kind of behavior he is abnormal in another. In America we institutionalize a man who thinks he is the son of a God or is a God but if the current thinking were that we were all descended from Gods, that kind of reasoning would be perfectly normal. Just as right and wrong are relative to time and place so are normal and abnormal from the ethical viewpoint.

F. The Pathological Viewpoint

From the pathological viewpoint abnormal psychology deals with people who are psychologically diseased to the point that they have lost their effectiveness in society and cannot be re-

garded as competent members of the group. The behavior disorders are relatively fixed patterns of attitudes and responses which are not adapted adequately to the society of which the afflicted person is a part. A rough division is found in the neuroses and the psychoses. The former is not committable to institutional care; the latter is extreme enough for care. Cameron recognizes eight types or syndromes among the behavior disorders—hypochondriacal disorders, fatigue syndromes, anxiety disorders, compulsive disorders, hysterical inactivation and hysterical autonomy, paranoid disorders, schizophrenic disorders, and manic and depressive disorders.¹⁰ From the pathological viewpoint a man is abnormal when he falls into any of these syndromes to the point that he has lost his effectiveness in living and finds adjustment to people difficult, if not impossible. The paranoid person is at large everywhere in society. In the factory he is difficult to handle and usually is a troublemaker because he knows he is imposed upon, cheated, discriminated against, and persecuted. In the office his human relations are just as difficult. In school he causes his teachers untold anxiety because he always has a chip on his shoulder. In the neighborhood he has his private battles with his next door neighbors. When his condition gets severe enough that he is a menace to society, he is institutionalized.

From what has been said it is apparent that from the pathological view normal and abnormal are relative terms. The paranoiac acts about as every person in his situation would act or could be expected to act. What he does under the circumstances is normal behavior for him. His personal development must be considered as well as the particular situation in which he finds himself now. Under the circumstances would his behavior differ much from any other person's behavior under the same circumstances? But the real criterion is based on his adjustment in society: it is here he is found wanting.

From the pathological view the so-called mental disease—actually in most cases the behavior is merely pronounced personal maladjustment—makes the person unfit for everyday living in a free society. When the maladjustment gets so severe that it is impossible to live with people, we are forced to institutionalize the patient for the protection of society and in an effort to rehabilitate him as a useful member of that society.

When we are dealing with the so-called “mental diseases”—and unfortunately too much of our abnormal psychology concentrates on them—we are dealing with learned forms of behavior which make it impossible for the person to live an effective life in a dynamic world. This is just another way of saying that because of his behavior he deviates from the way the masses live and therefore is unable to adjust to their patterned mode of adjusting to old and new ways. In the extreme forms of psychoses there is a rigidity and fixity that are incompatible with living in a changing world.

III. Summary

Who is normal or abnormal? Most people are normal most of the time. All of us are abnormal in some of our behavior occasionally. As seen from the discussion of the various points of view abnormality is relative to the criterion the abnormal person is measured against. If the person is measured by the behavior of the average accepted mode in society and he is found wanting, his behavior is abnormal. But as O'Kelly states “our primary interest will be in tracing the various circumstances rendering adjustment difficult or ineffective. Our criterion of “abnormal” will be oriented only to those aspects of behavior that are not effective in attaining optimal equilibrium.”

Actually the final determinant of abnormal behavior is the effectiveness with which the person lives in society. Is he getting along on a fairly harmonious basis with the people with whom

he associates? Is he able to earn his way through life by holding a job? Does he behave everywhere on a plane acceptable to his associates? In most circumstances is he on the right side of the law? Does he know what is "right" in his environment? From the statistical point of view he may be subnormal or supernormal and in statistics that may be significant. But from the psychologist's angle, what is important is an understanding of the causes of the deviant behavior and then knowing what to do to get acceptable behavior for the variant in any particular social group. Abnormal psychology deals with adjusting deviators to their environment. Abnormal psychology aims at helping people to acquire normal behavior.

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Chapter II

PSYCHOTHERAPY—
OUTLINE OF ITS HISTORY
AND PRESENT SITUATION

By

MARTIN GROTJAHN, M.D.,

and

SIGMUND GABE, M.D., *Los Angeles, Calif.*

PSYCHOTHERAPY -
OUTLINE OF ITS HISTORY
AND PRESENT SITUATION

HENRY CHOTKIN, M.D.

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Chapter II

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By MARTIN GROTJAHN, M.D., and SIGMUND GABE, M.D.
Los Angeles, Calif.

I. Introduction: Definition of Psychotherapy

Following the present day usage of the word "psychotherapy," this term will be used here as including a multitude of psychological methods, all having one thing in common—the intent to help a suffering individual through psychological means. The specific nature of this suffering cannot be strictly defined. Medical terminology does not cover all of its aspects, which embrace more than "mental illness." Philosophical terms will be avoided, because the relation of medical psychology to philosophical or religious issues is still not clarified. Sociological and anthropological terms will likewise be avoided, without however failing to acknowledge the indebtedness of psychotherapy to sociology and anthropology, as well as other borderline fields. But in the main, the description will limit itself to an outline of the history and the present situation of medical psychology as applied in the service of treating a patient. So defined it becomes obvious that psychotherapy, although practiced through the ages of history, is, as a scientific procedure, of recent origin.

II. The History of Scientific Psychotherapy to the Time of Sigmund Freud

Little is known of primitive man's attitude toward mental illness, but it is unlikely that he made any clear distinction between fate, belief or disease. He was a badly frightened human being who populated the world about him with the phantoms of his fears and anxieties. All the threats of a hostile world accentuated his sense of insecurity and he directed his efforts at coping with reality by means of magic-mystic wish-fulfillment. A similar approach to disease can still be seen in many primitive societies extant today.

The Ancient Hebrews show a certain familiarity with psychiatric clinical pictures, as is apparent, for instance, from the Biblical story of David's escape from captivity by feigning madness. However, mental illness is still attributed to demoniacal possession. The Biblical formula for dealing with the mentally disturbed is unequivocal and pitiless. In Leviticus it is written, "a man also a woman that hath a familiar spirit, or that is a wizard, shall surely be put to death; they shall stone them with stones; their blood shall be upon them." Such disposal of the mentally afflicted has manifested a remarkable viability, cropping up repeatedly through the centuries, almost to the present day. It bears witness to the extent and intensity of man's dread and hostility to the mentally ill.

It fell to the Greeks, with their rational and inquisitive genius, to make the first attempts to free mental disease from the web of mysticism and superstition, and to propose humane and rational ways of treating the mentally afflicted. Alcmaeon (550-500 B.C.) was the first philosopher to place the seat of reason in the brain and to regard mental disease a disorder of that organ. Protagoras proclaimed the importance of the individual in his celebrated dictum, "Man is the measure of all things." Em-

pedocles, (490-430 B.C.), who first propounded the theory of humors, which played so important a role in the explanation of disease processes both in ancient times and throughout the Middle Ages, also asserted that the emotions of love and hate are the fundamental source of change. Hippocrates, (460-370 B.C.), the most enlightened physician of antiquity and the father of medicine as a science and art, strove to wrest the field of mental disease from priest and soothsayer and place it in the domain of science. In his "Sacred Disease," a treatise on epilepsy, he argued: "It thus appears to me to be in no way more divine, nor more sacred than other diseases, but has a natural cause from which it originates like other affections . . . it is not a god which injures the body, but disease." In the main, Hippocrates' medical psychology was a physiological one, based on his theory of humors, with a place of central importance assigned to the brain. He contributed original descriptions of a number of psychiatric clinical pictures and devised a rational classification of mental disease in terms which are still in use today, although in somewhat modified connotation. Towards the therapy of mental disease, Hippocrates made no noteworthy contributions, contenting himself with traditional procedure, such as blood-letting and purging. Following Hippocrates, medical psychology became once more the province of the philosopher, with Plato, Aristotle, the Stoics and Epicureans contributing brilliant philosophical speculations and penetrating intuitions on the nature of man, his mind and behavior. In Plato's *Republic* is to be found one of the earliest references to special protection for the insane. "If anyone is insane let him not be seen openly in the city, but let the relatives of such a person watch over him at home in the best manner they know of; and if they are negligent, let them pay a fine."

After Greece became a mere province of the Roman Empire, the center of learning shifted to Rome. No notable advances in

psychiatry were made in Rome until the appearance there of Asclepiades, a Greek scholar and physician, who lived around the middle of the First Century, B.C. Asclepiades taught that mental diseases were due to disturbances of the emotions, which he called "passions of sensations." He individualized treatment and laid great emphasis on the physical and mental comfort of the insane; to that end he invented numerous devices to increase their comfort. He vigorously inveighed against putting the mentally ill in cells and dungeons, maintaining that they should be kept in well-lighted places since darkness excites terror. Fifteen centuries were yet to elapse before the humane and humanistic spirit that animated Asclepiades was to be victorious in freeing the mentally afflicted from their chains and dungeons. Even Asclepiades' famous disciple, Celsus (25 B.C. - 50 A.D.), was not averse to advocating the employment of physical cruelty or psychological torture to bring a mentally sick man to his senses. The physician Soranus (98-138 A.D.), who carried forward the humanitarian tradition of Asclepiades in the treatment of the mentally ill, condemned the maltreatment of mental patients and outlined humane and rational principles for their management. Galen (138-200 A.D.), the most renowned of Roman physicians, was a man of encyclopedic erudition and created a medical system of his own, which dominated the medical world until the Eighteenth Century. However, Galen made no original contributions to psychiatry, neither in therapy nor in clinical observations.

With the decline of the Roman Empire, a general lowering in the level of intellectual endeavor and achievement set in. In place of the scientific observation and objective study of man and nature, personal salvation and the hereafter absorbed all of man's attention. Mysticism, superstition, belief in witchcraft and demonology substituted for factual knowledge. The priest and religious bigot routed the physician from the field of mental

disease and for nearly twelve centuries psychiatry was severed from medicine. The church authorities, after some period of hesitation and uncertainty, decreed that all the mentally ill were possessed by demons. At first the attitude toward the possessed was considerate and the intervention of the saints was at times invoked in their behalf; but, "as the number of the mentally ill reached alarming proportions . . . passions were aroused and soon instruments of torture and burning fagots became the recognized tools of psychiatry." (Zilboorg)

The cruelty of inquisitor and magistrate failed to stem the rising tide of insanity which assumed epidemic proportion in the form of the flagellants and dance manias. The Western world became engulfed in a hunt for the devil and his agents; 'witches' and 'sorcerers' in countless thousands were tortured or burned to death. The last 'witches' were killed at the end of the Eighteenth Century.

While the light of classical science was eclipsed in the West, it was for a period rekindled in the East, where Arabian and Persian medicine carried on in the tradition of Galen. Arabian physicians established hospitals, libraries and academies in many cities. They regarded the mentally ill as divinely inspired, thus assuring them humane treatment.

The Renaissance ushered in revolutionary changes in psychiatry, as it did in many other fields of human endeavor. Psychology struggled once more for freedom from theology and man slowly became an object of investigation like other natural phenomena. The most penetrating student of the human mind the Renaissance produced was not a physician; he was the Spanish philosopher, Juan Luis Vives (1492-1540). In *The History of Medical Psychology*, Zilboorg¹ states: "Vives was not only the father of modern, empirical psychology, but the true forerunner of the dynamic psychology of the Twentieth Century." He credits Vives with the discovery of associations and with some intima-

tions of the existence of the unconscious. Vives gave a masterful description of the emotions that motivate man—the egoistic drives, love in its active and passive forms, the relation of hate to jealousy, the co-existence of contradictory feelings (later designated by Bleuler ‘ambivalence’), and the transformation of egoistical trends into higher social feelings (Freud’s concept of sublimation). A medical contemporary of Vives’, Paracelsus (1493-1541), spent his turbulent life in a crusade against the doctrine and practice of demonology. He adhered to the view that mental disorders have psychic causes and also propounded the existence of body magnetism, thus being the forerunner of mesmerism and hypnotism. Johann Weyer (1515-1588), devoted his medical talents to an objective study of mental phenomena in his patients, while at the same time treating them with great sympathy and compassion. He demonstrated that witches are actually mentally ill women. Weyer is regarded as the true founder of modern psychiatry, and Zilboorg says of him: “Weyer, more than anyone else, completed or at least brought closer to completion the process of divorcing psychology from theology.”

The Seventeenth Century saw great developments in the basic sciences and the physician gradually adopted the methods and basic postulates of the physical scientist. He tended to transpose the findings of physics and chemistry directly to the explanation of human phenomena. In the realm of psychiatry it led to a sterile mechanistic conception of the mind and its faculties. An exception was George Ernst Stahl (1660-1734), who was the first to differentiate between organic and functional psychiatric conditions.

The Eighteenth Century witnessed two major developmental trends of importance to psychotherapy: (1) the reformation of hospitals for the mentally ill and (2) emphasis on empirical observations and their systematization.

Mental hospitals were first established in the Fourteenth Cen-

ture, the earliest one being Bethlehem Hospital in London. In the ensuing centuries many hospitals for the insane were established in different countries. Conditions in all of them were unspeakably deplorable, patients being herded together in dark cells and dungeons, often chained, badly fed and physically maltreated. The spirit of the Eighteenth Century that produced the American War of Independence and the French Revolution, also asserted itself in the realm of the treatment of the insane. Philippe Pinel (1745-1826), a physician in charge of the Bicetre in Paris, with indomitable courage and determination, removed the chains from the mental patients and released them from the dungeons. He reorganized the hospital, provided workshops and recreation for the patients and forbade all forms of physical maltreatment of patients. He did the same later for the Salpetriere. Under his leadership, mental hospitals became a center for psychiatric study and therapy. The same spirit manifested itself independently in England, where William Tuke, a Quaker merchant, became so disturbed over the inhuman treatment of the insane that in 1796 he established York Retreat, a model institution where gentle and considerate treatment of patients was practiced. The influence of Pinel and Tuke made steady headway and finally produced mental institutions representative of institutional psychiatry today.

With this reformation of mental hospitals, and greatly stimulated by it, great interest and zeal developed in the description and classification of psychiatric syndromes. This was the era of systems, which aimed at presenting "a psychiatry without psychology." It culminated in the classification of mental disease by Kraepelin toward the latter part of the Nineteenth Century. This classification was based on neuropathology, prognostic criteria and clinical descriptive delineation, but lacked psychological dynamics. Kraepelin's importance for psychiatry and the subsequent development of psychotherapy should not be taken

lightly. If in the future little, or nothing, of Kraepelin's nomenclature and systematization remains, it is to his credit that psychiatry was separated from internal medicine, that it developed its own terminology, and that it began to form a body of knowledge of its own. Kraepelin staked out a claim for the new field of psychiatry. Without him, the psychiatric Renaissance might have originated in the field of philosophy, psychology, or even religion. Kraepelin and his school, in their defensive attitude towards philosophy and in their rigid adherence to organic medicine, safeguarded the new science of psychiatry as an independent discipline.

While science and the physician concentrated on the frankly psychotic, humanizing the regimes in the mental hospitals and delineating and classifying psychiatric syndromes, the large mass of neurotic sufferers was disregarded. An Austrian physician, Anton Mesmer, (1734-1815) focused attention on the neuroses. Mesmer claimed to have discovered "animal magnetism," a magnetic fluid which allegedly filled the universe and through which the stars exerted their influence on man. According to Mesmer, a disturbance in the balance of this fluid in any human being resulted in a variety of diseases. Mesmer professed to possess the ability to regulate the flow of magnetic fluid into or out of the patient's body and thus to reestablish the equilibrium necessary for cure. He set up a clinic in Paris in 1778, where he used his *baquet*, a kind of storage battery for animal magnetism with iron rods which the patients applied to ailing parts of the body. Mesmer, or one of his disciples, would, in great solemnity, stroke each patient with a magnetic wand, the effect of which would often be that patients lapsed into an ecstatic or convulsive "crisis," which was believed to be curative.

The scientific world met Mesmer's claims with disbelief and open hostility. The French Academy denounced mesmerism as a species of charlatanism. Mesmer contributed to this antagonism,

since he was an impetuous, arrogant and querulous man, who brooked no skepticism and browbeat opponents into acceptance of his ideas. Despite official opposition and condemnation, mesmerism continued to spread and its popularity increased. Patients suffering from a variety of ailments bore witness that they were cured by "animal magnetism." In 1787, a disciple of Mesmer, Marquis de Puysegur, produced a trance in a patient instead of the mesmeric crisis. In this sleep-like state, called "somnambulism," the patient was highly suggestible. In 1842, an English surgeon performed an amputation during a mesmeric trance. James Braid (1795-1860) became impressed with the subjective factor in mesmeric influence and concluded that it was not due to any mysterious magnetic fluid. He introduced the term "hypnotism" as a substitute for mesmerism. Thus, in spite of the fantastic aspect of his ideas, "Mesmer became the originator and bearer of a totally new orientation in psychological medicine, an orientation which brought psychotherapy to the forefront and with it ultimately the deepest insight yet attained by man into the inner workings of the human mind." (Zilboorg)

The "Episode of Mesmerism" did much to antagonize the medical profession. The defensive attitude of the physician toward psychology was understandable, in view of the fusion of psychology with mysticism and magic in the past. For some time to come, the science of psychiatry stood in need of the protection of medical science, as offered by Kraepelin.

The early history of hypnotism is inseparably associated with two French schools, that of Nancy and that of the Salpêtrière. A French country doctor, A. A. Liebault (1825-1904), practicing in the little town of Nancy in Eastern France, became interested in hypnosis in 1864. He used it on his peasant patients and reported his results in a monograph. Liebault's work went almost unnoticed until he was joined by Bernheim (1837-1919), who was professor of the local medical school. These two investiga-

tors treated and studied a great number of patients, and came to the conclusion that the phenomena of hypnosis depended on suggestion. Suggestibility is not a trait of hysterics alone but of human beings in general. These findings clashed with the views of another great French student of hypnosis, Charcot, who regarded hypnosis as a physiological phenomenon confined to hysterics. The controversy ended in a victory of Bernheim's views.

Charcot (1825-1893) was a neurologist who became interested in hypnosis and in 1878 set up a clinic for the study of hysteria and hypnosis at the Salpetriere. Charcot's main emphasis was on the objective neurological findings in hysteria and their reproduction and obliteration by means of hypnosis. He believed that the basic defect in hysteria was an organic one and regarded the psychological phenomena as by-products of an altered physical state. Although Charcot's theoretical stand placed him in the conservative ranks of the organically-minded psychiatrists, his influence was a progressive one. He was a great teacher, and psychiatrists from all over the world were attracted to his clinic, which became the first center of post-graduate psychiatric training in the world.

Pierre Janet continued to study hysteria. He traced hysterical symptoms to events in the patient's life and removed them by means of hypnotic suggestion. He was the first to use the concept of the "unconscious," but understood it in a non-dynamic sense, and believed that hysterics suffer from degeneracy.

At the end of the Nineteenth Century, hypnosis and suggestion were widely used. Such men as Foret in Switzerland, Moll in Germany, Bianchi in Italy, Bechterew in Russia, Bramwell in England, became active workers in the field. In the United States, G. Stanley Hall and Morton Prince, among others, used hypnosis in their investigations.

The therapeutic limitations of hypnosis motivated Freud to search for better methods, which he developed as "psycho-

analysis," and hypnosis lapsed into disuse. Recently interest in hypnosis has revived, but this research is closely related to analytic theories and experience. A number of investigators, among them C. R. Hull, P. C. Young, and M. G. Erickson have been devoting attention to it. A variant of hypnosis, hypnoanalysis, is still in the initial stages of exploration as a therapeutic agent. It utilizes hypnosis to facilitate the recovery of forgotten traumatic events and further integration.

During the emergency of World War II the effect of hypnosis, achieved with the help of drugs, gained considerable therapeutic importance. (Grinker-Spiegel²) It may develop that "Narco-Synthesis" was of little benefit to the patient, but of great benefit for the experience of the physician. Faced with the task of rendering emergency psychiatric help to vast numbers of psychiatric casualties, the physician found his psychological training hopelessly inadequate. The physician demonstrated the existence of dynamic psychological forces in his patients. This experience overcame the physician's resistance to dynamic psychiatry and stimulated his interest in psychotherapy. An up-to-date survey of hypnotherapy was recently published by Margaret Brenman and Merton M. Gill (Sig. Gabe).

III. Sigmund Freud and Psychoanalysis

A new era in psychiatry was initiated by Sigmund Freud. He was born in 1856 at Freiberg in Moravia, now Czechoslovakia. At the age of four Freud and his family settled in Vienna, where he grew up and was educated. He at first intended to study law, but after hearing Goethe's essay on "Nature" read at a public lecture, he decided to become a physician. While in medical school he began research on neurological problems in Ernst Bruche's laboratory. After graduation, in 1887, he continued research on the central nervous system and published the results in a series of scientific papers. They constitute landmarks in the

science of Neurology, as for example his work on organic brain diseases and a short and pertinent study of aphasic speech disturbances. In 1885, while a lecturer at the University of Vienna, Freud was awarded a travelling fellowship and went to study hypnosis under Charcot.

In 1886, Freud married and started private practice in Vienna as a specialist in nervous diseases. It was a step of historic significance that Freud was forced to change from the microscopic study of brain tissue to the treatment of neurotic people, of whom there was such an abundance in the Vienna of Victorian times. He relied on hypnosis, and to perfect this technique went to Nancy in the summer of 1889. Freud described his experience at Nancy in these words: "I witnessed the moving spectacle of old Liebault working among the poor women and children of the labouring classes. I was a spectator of Bernheim's astounding experiments upon his hospital patients, and I received the profoundest impression of the possibility that there could be powerful mental processes which nevertheless remained hidden from the consciousness of man."

Back in Vienna, Freud practiced with an older colleague, Joseph Breuer, a distinguished Viennese clinician, who had been employing hypnosis for some years. Breuer introduced the innovation of questioning his patients under hypnosis about the onset of their symptoms. In the hypnotic trance, patients could recall forgotten experiences which were not available to memory in the conscious state, and the recollection of traumatic events was usually accompanied by the discharge of strong effects. Breuer thought hysteria resulted from emotions which had found an abnormal outlet. He attributed the curative results of his treatment to an abreaction of dammed-up affects. He labelled his method *catharsis*. Freud was impressed with Breuer's innovation, which relieved patients of their symptoms, and gave an insight into the psychological processes.

Together with Breuer, Freud undertook to treat hysteria by means of the cathartic method. They published the results of their collaboration in 1895 in a monograph entitled *Studies in Hysteria*. It presented three significant discoveries: hysterical symptoms are the result of past emotional disturbances; mental processes can remain unconscious yet produce overt effects not unlike conscious ideas; and emotions can be transposed from the psychical sphere to the somatic, a process which Freud designated *conversion*. The "*Studies*" met with a hostile reception by the medical profession and shortly after its appearance, the collaboration between Freud and Breuer ended.

Freud then decided to discontinue the use of hypnosis because of its limitations. He retained only the use of the couch, and the custom of sitting behind the patient. In place of hypnosis he substituted *waking suggestion*. He relied on persuasion and encouragement to make the patient recall forgotten events, sometimes pressing his hand to the patient's forehead to intensify the suggestion. Freud soon discovered that by suggestion alone he could not induce patients to recall traumatic experiences which led to neurosis. He began to look about for a modification in the therapeutic procedure. The experiment with waking suggestion lasted a short time (it started after 1895 and was given up by 1899) but it led to a pivotal discovery—the concepts of *resistance* and *repression* as manifestations of the patient's *unconscious*. Freud found that he had to expend considerable mental effort to force the patient to remember the traumatic experience. From that he concluded that "the expenditure on the part of the physician was evidently a measure of *resistance* on the part of the patient. It was only necessary to translate into words what I myself observed and I was in possession of the theory of *repression*." The discovery of *repression* changed the methods and aims of therapy. In addition to abreacting dammed-up affects, it became necessary to uncover and replace them by acts of conscious judgment.

Since persuasion was often ineffective, Freud tried to approach the unconscious from another direction. He encouraged the patient to express the thoughts which occurred to him without any conscious selection whatever. He called this method "Free Association." He asked the patient to report everything he thought, whether it seemed important or not, which became the "basic rule" in conducting psychoanalysis. Free association replaced the frontal attack on repression which had been made through the use of hypnosis and suggestion. The patient is not consciously aware of the material which has been repressed, and all of the thoughts which occur to him in the analytic situation are in some way associated with repressed conflicts. Freud found that in the stream of free associations, the repressed unconscious gradually appeared and it became the function of the analyst to recognize and interpret the unconscious associations made by the patient during the hour. Thus, free association and interpretation, and especially the interpretation of the resistance within the transference situation, became the major tools in the new therapy which Freud originated and named "Psychoanalysis."

The concepts of "Unconscious," "Resistance," and "Repression" were among the earliest of Freud's formulations but additional research was necessary before psychoanalysis became the effective therapy we know it to be today. Freud advanced the development of psychoanalysis further through his understanding of "Transference" which he described for the first time in his report of the psychoanalysis of Dora, published in 1905, although written in 1899. Transference refers to the emotional reaction of the patient toward the analyst, in which the patient develops feelings toward the analyst which are the same, or similar to, the feelings and emotions which he felt in his childhood toward his parents or other authoritative figures. The interpretation of the transference provides the most powerful device for overcoming the patient's resistance to facing disturb-

ing emotional experiences. The emphasis which Freud placed on transference and resistance is apparent in his statement in the *History of the Psychoanalytic Movement*:

"It may therefore be said that the psychoanalytic theory endeavors to explain two experiences, which result in a striking and unexpected manner during the attempt to trace back morbid symptoms of a neurotic to their source in his life-history; viz., the facts of transference and resistance. Every investigation which recognizes these two facts and makes them the starting point of its work may call itself psychoanalysis."³

In 1898, Freud published his important research on *The Interpretation of Dreams*. He found that behind the *manifest content*, which often appeared absurd and meaningless, there lay the *latent thoughts*, which usually referred to repressed unconscious wishes. The latent thoughts were translated into the manifest content by the mechanisms of condensation, displacement, dramatization, symbolization and secondary elaboration. The agency that compels this disguise of the latent thoughts Freud named *the censor*. Freud proved that the structure of dreams was in all essentials analagous to symptom formation. The interpretation of dreams became a useful tool in therapy, for it turned out that "infantile amnesia is for the most part overcome in connection with the interpretation of dreams." Freud considered the study of dreams by means of free association "the royal road to the unconscious," without which treatment cannot become effective.

In his *Psychopathology of Everyday Life*,⁴ published in 1904, Freud showed that everyday slips and mistakes have psychological meaning and are unconsciously motivated. The result of these investigations was to establish the determinism of all mental acts, to prove the existence of repressions in the so-called normal as well as in the neurotic, to adduce irrefutable evidence

of the existence of the Unconscious and to lay "the foundation for a new and deeper science of the mind."

Almost the entire work during this early period was done by Freud single-handed and in complete isolation. For nearly ten years, 1896-1906, Freud was shunned and ridiculed. That was due largely to the "resistance" to Freud's discoveries about the Unconscious, the sexual etiology of the neuroses, and the existence of infantile sexuality. In the *History of the Psychoanalytic Movement*, Freud states: "I sacrificed unhesitatingly my budding popularity as a physician and growing practice in nervous disease because I searched directly for the sexual origin of the neuroses." Freud was not embittered by this universal antagonism, because he realized that he had destroyed one of humanity's fondest illusions, the belief in the "innocence of childhood which every individual defends by his infantile amnesia." In retrospect Freud could even write: "When I look back to those lonely years from the perplexities and pressure of the present, it seems to me like a beautiful and heroic era. The 'splendid isolation' was not lacking in advantages and charms."

Freud published his views on sexuality in 1904 in a monograph entitled *Three Contributions to the Theory of Sexuality*,⁵ which he amended and extended in subsequent editions and which goes under the designation of the Libido Theory. In his *Autobiography*⁶ he summarized his views on sexuality as they gradually crystallized: "The sexual function, as I found, is in existence from the very beginning of the individual's life . . . It begins by manifesting itself in the activity of a whole number of *component instincts*. These are dependent upon *erotogenic zones* in the body . . . to begin with they are non-centralized and predominantly *auto-erotic*. Later they begin to be coordinated; a first stage of organization is reached under the dominance of the *oral* components, an *anal-sadistic* stage follows, and it is only after the third stage has at last been reached that the primacy

of the *genitals* is established and that the sexual function begins to serve the ends of reproduction . . . I gave the name of *libido* to the energy of the sexual instincts . . . As a result either of the excessive strength of certain components or of the experiences involving premature gratification, *fixations* of the libido may occur at various points in the course of its development. If subsequently a repression takes place, the libido flows back to these points (a process described as regression) and it is from them that the energy breaks through in the form of a symptom . . . the localization of the point of fixation is what determines the *choice of neurosis* . . . The process of arriving at an *object* . . . takes place alongside of the organization of the libido . . . the first love-object in the case of both sexes is the mother . . . Later, but still in the first years of infancy, the relation known as the Oedipus Complex becomes established; Boys concentrate on their mother and develop hostile impulses against their father as being a rival, while girls adopt an analogous attitude. . . . A *period of latency* follows, during which the *reaction-formation* of morality, shame and disgust are built up. . . . At puberty the impulses and object relations of a child's early years become reanimated, and amongst them the emotional ties of his Oedipus Complex. The sexual life of puberty is a struggle between the impulses of the early years and the inhibitions of the latency period."

Gradually a small circle of men gathered around Freud. The spread of Freud's ideas gained impetus when a group of Swiss psychiatrists in Zurich under E. Bleuler, who headed the psychiatric institution at Burgholzli, began to show interest in the study of psychoanalysis. One of the most gifted of that group was C. G. Jung, who made a study of associations, interpreted some of the mental products of schizophrenia in the light of archaic thinking and contributed the concept of the psychological complex. In 1910, when the International Psychoanalytical Associa-

tion was organized, Freud insisted that not himself but Jung become its first president.

An important extension of the libido theory resulted from Freud's investigation of the psychoses. In the now famous Schreber Case, Freud used as the subject for analytic scrutiny the autobiography of the paranoiac Schreber. From that analysis Freud concluded that "in paranoia the liberated libido becomes fixed on the ego, and is used for the aggrandizement of the ego," and that "paranoiacs are endowed with a fixation at the stage of narcissism." This new insight necessitated a change in the schema of libido organization to include an additional stage—Narcissism. Originally all the libido is invested in the ego and has the self as an object. The individual in his development learns to invest some of his libido in objects, which thus becomes *object-libido*. In the psychoses, the patient has withdrawn the object cathexes into his narcissistic reservoir and has therefore lost his ability to establish stable emotional relationships with his environment. For that reason Freud designated psychoses as the narcissistic neuroses, and explained the special psychotherapeutic difficulties of working with psychotics by their narcissistic state.

While Freud was the main architect of the libido theory, significant contributions were also made by several of his disciples. Karl Abraham in particular made important contributions to the knowledge of the pregenital stages and showed how they serve as fixation points for the psychoses and some of the neuroses and character disturbances. He also—and here he followed the lead of Freud, who first delineated the analsadistic character—demonstrated how the different libidinal stages leave precipitates in the personality which determine various character traits.

Also from the start of his research in psychopathology, Freud postulated a dual instinct theory, according to which conflicts result from the clash of two antagonistic instincts. He at first formulated the conflict as occurring between ego instincts and the

sexual instinct. With the development of the concept of narcissism, this distinction was no longer tenable, since both the ego strivings and the sexual strivings stemmed from the same reservoir of libido. In 1920, Freud published his essay *Beyond the Pleasure Principle*,⁷ which offered a new solution. He reinstated the dichotomy of instincts, a contrast between "the sexual instincts in the widest sense of the word" and "the aggressive instincts, whose aim is destruction." Freud found support for the theory of a destructive instinct in the phenomena of masochism, some aspects of self-destructive tendencies, and the repetition-compulsion. Freud gave to his new concept of the instincts the widest biological application. "The instincts . . . separated themselves into two groups: the erotic instincts, which are always trying to collect living substances together into ever larger unities, and the death instincts, which act against that tendency and try to bring living matter back into an inorganic condition." Freud advanced the concept of a "death instinct" in a tentative manner. The time has not arrived yet to pass judgment on the scientific validity of Freud's last version concerning the death instinct. Practical questions of therapy are not directly involved in the discussion of these fundamentally theoretical issues.

New fields of psychoanalytic investigation were opened in the 1920's, when Freud focused his attention on the ego-institutions. Heretofore, psychoanalysis was primarily occupied with the psychology of the unconscious levels of the mind. Later Freud applied himself to investigation of the repressing forces of the personality, or the role of the ego in the neurotic conflict. The results of that investigation formed the subject of three essays, *Beyond the Pleasure Principle*, *Group Psychology* and *Analysis of the Ego* and *The Ego and the Id*. According to Freud's newer concepts, "The mental apparatus is composed of an "id," which is the reservoir of the instinctive impulses, of an "ego," which is the most superficial portion of the id modi-

fied by the influence of the external world, and of a "super-ego," which develops out of the id, dominates the ego and represents the inhibitions of instinct characteristic of man." The ego mediates between id strivings, the demands of external reality and the dictates of the super-ego. In its role as mediator, the ego becomes a prey to anxiety whenever it is forced to acknowledge its weakness. This aspect of psychoanalysis was called by Freud "Metapsychology."

The problem of anxiety preoccupied Freud most of his life and to it he devoted his last clinical work, *Inhibitions, Symptoms, and Anxiety* (1926).⁸ He viewed the experience of birth as the prototype of subsequent states of anxiety. Otto Rank extended that concept into the central core of all subsequent neurotic difficulty and geared his therapy to it. Freud, on the contrary, regarded anxiety as a danger signal to the ego that it is about to be confronted with a traumatic situation. He believed that "each period of the individual's life has its appropriate determinant anxiety." To protect itself from anxiety-provoking situations, the ego employs a variety of defenses.

To the study of these defenses and their consequences in symptom formation and character structure, Anna Freud made an outstanding contribution in her work, *The Ego and the Mechanisms of Defense*.⁹ Anna Freud lists the defense mechanisms as follows: regression, repression, reaction-formation, isolation, undoing, projection, introjection, turning against the self, reversal and sublimation, denial, identification with the aggressor, and intellectualization. A large share of the work of analysis is devoted to unearthing the defenses and their substitution by more mature response. In the words of Anna Freud, "In analysis, the defensive processes are reversed, a passage back into consciousness is forced for the instinctual impulses and affects which have been warded off and it is then left to the ego and the super-ego to come to terms with them on a better basis."

The aim of psychoanalysis is to strengthen integrative ability of the ego so that it can deal with unconscious instinctual tendencies, by means of conscious judgment rather than through repression. Repression represents a costly method of warding off ego-alien impulses. The repressed tendencies fail to keep step with the development of the rest of the personality because they are unconscious, and impervious to the influences of the environment, and remain unmodified. The ego is deprived of considerable energy because of the necessity to continue the repression of these impulses, so additional energy is expended to keep these tendencies from expression. The result is a restriction and impoverishment of the ego.

Despite the mechanism of repression, the repressed instinctual tendencies constantly try to force their way into consciousness. This is prevented by the defenses which have become unconscious and through conscious control and selection. The conscious "suppression" of material is achieved through "voluntary control," but when this control is relaxed, the derivatives of the unconscious impulses may appear in the free associations of the patient. To reduce the tendency to suppress material which the patient feels cannot be discussed, he is asked to lie on a couch, to try to relax, and to verbalize his ideas, feelings, and physical sensations of which he becomes aware of by self-observation, without selecting or suppressing any of them. Through the analysis of the attitudes and feelings which the patient has transferred to the analyst, the patient overcomes his resistances to understanding his unconscious conflicts. However, insight alone is not sufficient to bring about integration of the repressed tendencies into the ego. Opportunity must be provided for testing out more appropriate ways of handling the repressed emotions. This "corrective emotional experience" is also provided by the transference situation, where the analyst's consistent, objective and understanding attitude counteracts the parental attitudes which were often harmful earlier.

The recollection of traumatic experiences, the removal of the infantile amnesia and the reconstruction of the history of the patient's neurosis are important therapeutic tasks; however, they do not occupy the foreground of the therapeutic interest. Preeminence is given to the process of ego maturation through intellectual insight and emotional retraining (Sig. Gabe).

IV. Other Schools of Psychotherapy

After the resignation of Bleuler from the Psychoanalytic Association, Alfred Adler separated himself from the organization in 1911, and C. G. Jung in 1913. In Freud's opinion, both men attempted to circumvent the general hostile reaction toward psychoanalysis by sacrificing the importance of sexuality in the etiology of neurosis. Adler abandoned the libido theory, attributing to the "will-to power" and reaction to constitutional inferiority sole responsibility for character formation and production of neurosis.

Alexandra Adler, daughter of Alfred, defines the steps in Adlerian psychotherapy as follows: (1) the therapist gains understanding of the patient's basic conflicts and the goals he is striving to attain with his symptoms. (2) The patient is made aware of the mechanisms by being given understanding and insight; and (3) the patient is guided in new ways of adjustment. "During the whole course of treatment a friendly encouraging attitude is maintained."

Later developments have shown that Adler and his co-workers had little to contribute to psychological medicine. Their emphasis upon social influences and environmental factors, and their appeal to a socialistic ideology influenced greatly teachers and educators in Europe. Their work proved more of a stimulus to progressive education than to scientific psychotherapy. Their influence prepared the ground for the later teachings of child analysts, especially those of Anna Freud.

After seceding from the Psychoanalytic Movement in 1913, Jung was free to develop his penchant for speculative and mystical thinking. He labelled his system "Analytical Psychology." Jungian psychology regards the libido as "a really universal, purposive life force." Out of this universal stream are differentiated first races, then individuals. This process Jung designated "individuation." In the analysis of individuals, progressively less personal and more universal areas are reached. The more universal levels of the psyche represent the "Collective Unconscious," the contents of which consist of the racial heritage. The individual psyche consists of several layers. The most superficial aspect, "the Persona," is the socialized part of the total personality and includes the ego-interests and conventional sanctions. "The Ego" is the next layer, which is partly conscious and socialized and contains the past episodes and experiences of the individual. "The Shadow" is the layer that represents the Collective Unconscious. Its contents are anti-social, even criminal, diabolical. The contents of the Shadow contain a number of archetypes, among which are the "Animus" and the "Anima," the former being an unconscious mate-ideal in the female psyche, and the latter a mate-ideal in the male psyche.

Jungian analysis explores "First of all those associations which illuminate the personal levels of the psyche, and then, as a second but decisive stage in the analysis, they try to detect connections between expressed contents and the internal collective heritage." Great stress is laid on the role of religion in personal adjustment. "The development of an intellectually and emotionally satisfying religion is considered an essential aspect of the therapeutic process in many cases." The therapeutic approach to patients is varied according to the type of their personality. Two general types are recognized, the introvert and the extrovert. "The introvert demands a high degree of coherence in his interpretation of his various problems and of their re-

lations to his environment, including even the total cosmic environment. The extrovert, on the other hand, may attain adjustment on a more pragmatic or positivistic basis."

Jung's theoretical system, and the therapy that flows from it, rejects the biological and genetic approach to psychological problems and tasks, offering instead teleological and finalistic constructs. It comes closer to metaphysical speculation than to the scientific inductive methodology that animates psychoanalytic thinking. Late developments have shown how Jung's increasing resistance against the individual unconscious as contrasted to the collective unconscious led to scientific sterility. The term "collective unconscious" did not originate in Jung's writing, but was coined by Freud in his book, *Totem and Taboo*. Jung's later theories concerning racial psychology definitely marked the end of his career as a scientist.

Among the other early students of psychoanalysis, Wilhelm Stekel must be mentioned. He is an outstanding exponent of the "intuitive school" of psychotherapy. In earlier years he contributed illustrative material to the understanding of dreams. His later and extensive work gave numerous examples of fine intuitive, human psychological understanding with utter disregard for theoretical scientific considerations or methodological consistency. The final result was a hodge-podge of skillful management and shrewd guessing.

Recently the role of culture as the moulder and selector of human needs and potentialities has been receiving more serious study and constitutes the most active sector of psychologic research. In this realm too, Freud was a pioneer and active worker for many decades. In *Wit and Its Relation to the Unconscious* (1905),¹⁰ Freud ventured into the field of esthetics. In *Totem and Taboo* (1913),¹¹ Freud inquired into the origin of the basic human social institutions of morality and religion and indicated how they stem from the influence of the Oedipus

Complex. In the last decade of his life, which was marked by great suffering as a result of a recurrent malignancy of the jaw, which was already diagnosed in 1923, Freud resumed his study of social institutions and religion in several monographs: *The Future of an Illusion*¹² (1927), *Civilization and its Discontents*,¹³ (1930), and *Moses and Monotheism*¹⁴ (1939). When the armies of Nazi Germany occupied Vienna, Freud was forced to flee Austria, and settled in London, where he died on September 23, 1939.

Karen Horney is the exponent of the group of scientists who emphasize the role of the social environment in shaping the individual. She began by questioning Freud's views on feminine psychology and ended by discarding the bulk of the fundamental tenets of psychoanalytic libido theory. Freud postulated the instinctual drives and their transformations as the energetic source of mental phenomena. Horney preferred the term "striving for safety," and deduces neurotic conflicts and neurotic character structures from it. "The relevant factor in the genesis of neurosis is then neither the Edipus complex nor any kind of infantile pleasure strivings but all those adverse influences which make a child feel helpless and defenseless and which make him conceive the world as potentially menacing." The feeling of helplessness is labeled by Horney as "basic anxiety." To cope with this basic anxiety, the individual develops "neurotic trends." These trends tend to become rigid and compulsory because anxiety develops the moment they fail to operate. Neurotic trends may be mutually contradictory and incompatible and thus generate conflict. They tend to "alienate the individual from himself," thus impairing creative ability and capacity for happiness. Furthermore, the neurotic trends frustrate the purpose for which they were adopted, by impairing interpersonal relationships through an exaggerated dependency on others or through generating hostile reactions. According to Karen Horney the neurotic trends pro-

duce neurotic character structure which uniformly manifests the following traits: compulsory conflicting strivings, propensity to develop manifest anxiety, impairment in interpersonal relationships, marked discrepancy between potentialities and actual attainments.

Horney's theoretical views find expression in her therapy. "My main objective in therapy is, after having recognized the neurotic trends, to discover in detail the functions they serve and the consequences they have on the patient's personality and on his life." Horney claims that she accepts Freud's basic tools of therapy—free association, interpretation and transference analysis—but differs from him in the use she makes of them. She interprets to the patient not the past events which have generated the neurosis and moulded his character, but the manner in which his neurotic pattern functions in the present and the injurious consequences that flow from it. She also believes in actively directing the analysis. "As soon as I believe that the patient is running into a blind alley, I would not hesitate to interfere most actively and to suggest another way." Not only does she influence the patient's direction of associations, but she does not hesitate to manipulate the psychic forces which she believes might aid in overcoming his neurosis, such as creating in the patient "a constructive discontent with himself," and stimulating his will power to struggle against his neurotic trends. Horney denies that an attitude of tolerance and objectivity is either desirable or possible in a therapeutic relationship. "Instead of tolerance, or rather pseudotolerance, there should be a constructive friendliness."

The study of Freud's work shows clearly that Freud never neglected the formative power of social influences upon the individual. The emphasis upon social influences can easily be combined with the fundamentals of psychoanalytic theory. This has been demonstrated repeatedly by such writers as Otto

Fenichel, F. Brown, Erik Homburger-Erickson, and Abram Kardiner (Sig. Gabe).

Facilities for Teaching and Training in Analytic Psychotherapy

A short note about the teaching facilities for analytic therapy may be justified in this place. The first systematic course of training in psychoanalysis was organized not in Vienna, the cradle of psychoanalysis, but in Berlin in the early 20's of this century. The Berlin Psychoanalytic Institute developed the first psychoanalytic curriculum and divided it into three parts—didactic analysis of the candidates, theoretical seminars and practical supervised work. Later similar training institutes for psychoanalysis were formed in London, Vienna, and other continental centers. The first psychoanalytic institute in the United States was brought into existence in 1931 in New York under the leadership of Dr. A. A. Brill, with the assistance of the late Monroe Mayer. It was organized according to the model of the Berlin Institute. At the present time there are psychoanalytic institutes in Boston, Chicago, Detroit, Los Angeles, two in New York, in Philadelphia, San Francisco, Topeka, Washington, D. C., and Baltimore. The Chicago Institute attained a position of eminence as a result of the unique collective work it carried on in psychosomatic medicine. Special mention must be made of the Topeka Institute for Psychoanalysis, which is a part of the Menninger Foundation in Topeka, Kansas. Under the leadership of Karl Menninger this foundation has made an outstanding contribution to the technique of teaching psychiatry and psychotherapy.

The analytic training institutes, as Sandor Rado has pointed out recently, saved the art and science of psychoanalysis, but they could offer no full compensation for the exclusion of psychoanalysis from the medical schools. In the United States this

exclusion proved harmful to both sides. The establishment of the Psychoanalytic Clinic for Training and Research at Columbia University, and most recently at Yale University as well as in several other universities, has changed this situation. The Columbia plan of graduate residency training in psychoanalytic medicine, based on the facilities of the university, has now been in operation for three academic years. An outstanding feature of the Columbia system, as developed with the pioneer spirit of Sandor Rado, which requires three years of full-time graduate work, is the combination of analytic clinical instruction with the theoretical program from the beginning. Columbia University has a staff of twenty-one analysts to provide the personal analysis of all medical students.

The relation between analytic psychotherapy and clinical psychology is not yet clarified. The proceedings of a conference devoted to this topic have been recently published under the title *Training in Clinical Psychology*,¹⁵ (Josiah Macy, Jr. Foundation Conference, New York, 1947). For any psychoanalyst trying to orient himself about the relations between psychoanalysis and clinical psychology, this little booklet will be as important as the first aid kit is to a physician. More than a dozen different aspects are outlined by as many speakers, and all the discussions are highlighted and summarized by the Chairman of the meeting, Dr. Lawrence S. Kubie.

Lawrence Kubie gives an informative illustration of the basic unsoundness of our present system of medical education, particularly so far as the system concerns psychiatric training. The actual span of years in which a psychiatrist can effectively use a technique which has taken forty years to learn, is something like twenty years on an average. Therefore, Kubie concluded, the community has a direct interest in seeing whether it is not possible to train a man to do really sound and intelligent psychotherapy, and to learn to do it within six years instead of taking

twelve, as it does now from the start of medical school. Medical psychologists would be ready for work at about the age of twenty-eight; "with another two or three years of closely supervised work they would be fairly seasoned therapists with far more training in psychotherapy than most psychiatrists have had when they take their Board examinations, except for those with analytic training."

Carl Binger, in his fascinating and thoughtful contribution, emphasized some doubts of a more general nature. "I am not myself too optimistic about the mass production of therapists, no matter by what kind of training. The most challenging and pressing task is to understand the causes of neurotic illnesses and to do what we can to prevent them. . . . I do believe that both the clinical psychologist and the psychiatric social worker can make significant contributions to these two problems; perhaps greater than the person who is, by force of circumstance, committed to therapy."

The last word is said by Ives Hendrick, who designates himself as a "member of the preponderant group in the American Psychoanalytic Association who did not favor, and do not favor today, the training of laymen of any professional category for psychoanalytic therapy." He gives a very instructive and historic outline of the development of the changing attitude toward laymen; he analyzes the difference between the Continental and the American scene, and reports the decisions taken by the American Psychoanalytic Association in the year 1947, and the suggested changes in the year 1948.

The value of this conference as reported in this book does not rest on any of its conclusions or decisions. The conference was, so to speak, a roll call for everyone concerned to take a stand in the rapidly changing situation, to do the necessary spade work and to get oriented in this field for later cooperative work.

The question of lay analysis—meaning the application of

psychoanalysis as a method of treatment by persons who have not studied medicine—is not yet settled. Besides the truly analytic implications which have been discussed in detail by Sigmund Freud and Ernest Jones, and besides sociological consideration, this problem is also a question of organization. The fact remains that until recently no group of lay analysts saw fit to set up standards and training schools for the education and training of non-medical analysts. As a rule, lay analysts always have related themselves more closely to their medical colleagues and their training than to psychologists or philologists. Only the future will show whether Theodor Reik and his new organization, the National Psychological Association for Psychoanalysis, can be considered as a starting point of a new analytic educational organization.

Generally speaking there is a great upswing in the theoretical discussion of analytic training and in the practical approach to the organization of analytic training schools. The prerequisite for success in analytic training is the personal analysis of the candidate. Such highly individualized procedure constitutes as a matter of course a bottleneck in the turning out of qualified psychoanalysts. Only after this personal analysis of the physician, lectures and seminars are considered of real value for the candidate.

The special aspect of training analysis have been studied and described by Otto Fenichel, Ernest Jones, Maria Sharpe, Hans Sachs, Lawrence Kubie, Maxwell Gittelson, Sandor Rado, Martin Grotjahn, and an ever-increasing number of approximately 150 to 200 analysts, actively engaged in the conduct of training analyses (Martin Grotjahn).

V. Recent Developments in the Field of Psychotherapy

The scene of the most rapid change and progress in psychological medicine and in its practical aspect, psychotherapy, is at

present probably in America. Since the advent of reaction and repression in Europe, the trend of American scientists to study psychoanalysis in Europe has been reversed. With the help of emigrating psychoanalysts from Europe, psychotherapy in this country has developed rapidly. The tradition and training of the analysts of the old country combined with the spirit of open-mindedness and an eminent sense of practicability, have given the American scene a good setting for a new start. It might be said that the First World War called attention to the existence of psychiatry, while the Second World War showed psychiatry, and more specifically, psychodynamic therapy, at work. It was the war experience that finally broke down the professional resistance of medical men against things psychological. After all, the medical student had to forget that his first patient was a cadaver, and it was new and difficult for him to discover the suffering person.

A. Recent Advances of Psychotherapy in the Field of Psychosomatic Medicine

It is not the aim of this report to review the entire field of psychosomatic medicine. That is adequately covered in such outstanding books as *Emotions and Bodily Changes*¹⁶ and *Psychosomatic Diagnosis*¹⁷ by Flanders Dunbar, and *Psychosomatic Medicine*¹⁸ by Edward Weiss and Spurgeon English. After this report was written, a new book was published which is of outstanding importance: *Studies in Psychosomatic Medicine. An approach to the Course and Treatment of Vegetative Disturbances*,¹⁹ edited by Franz Alexander and Thomas M. French, with the cooperation of the staff members of the Chicago Institute for Psychoanalysis (The Ronald Press, N. Y., 1948). This book is a collection and reprinting of the Institute's pioneer work on psychoanalytic psychosomatic research and contains almost all papers which were originally intended to be included here in a

detailed bibliography. It was found advisable to refer to the book now instead of the original sources.

It is the aim of this report to show the inroad of psychological thinking and treatment into internal medicine. A new turn in the practice of medicine occurred with the application of psychotherapy to the management of somatic illnesses. The psychotherapeutic procedure consisted of three steps: (1) taking the patient's history in the form of a "Free Associative Anamnesis" (a term coined by Felix Deutsch), (2) evaluating the patient's personality, and, (3) the psychological meaning of the somatic symptoms, applying the understanding thus gained in the form of psychotherapy. The results of this therapy are already so well established that psychotherapy has become a distinct tool in the hands of the physician.

The theoretical and practical pioneer work of psychosomatic medicine and therapy was done by Franz Alexander. Alexander has clarified the theoretical fundamentals of psychosomatic medicine with the help of terms and concepts like "vector." It is interesting to note that the fundamental difference between hysterical conversion symptoms, vegetative neuroses and organic diseases are clarified only recently in the history of psychological medicine. A conversion symptom is a symbolic expression of a well defined emotional tension, and functionally it is an attempt at relief. The symptom is expressed by the voluntary neuromuscular or sensory perceptive systems whose original function is to express and relieve tension. The symptom expresses both the repressed emotion and its rejection, and affords only partial relief to the repressed emotion. A vegetative neurosis is not an attempt to express an emotion symbolically, but is the physiologic concomitant of constant or periodically recurrent emotional tension states. In the case of hypertension, for example, the patient is under a frequent or constant tension of a repressed emotion of aggression, which he is unable to express directly nor

with the help of a neurotic symptom because of a neurotically exaggerated sense of shame or guilt. This tension induces the vegetative nervous system to react with high blood pressure. A vegetative neurosis thus consists of a psychogenic dysfunction of a vegetative organ which is not under control of the voluntary muscular system. Such chronic tension states can finally lead to the breakdown of the organ resulting in actual organic changes.

Emotions have a dynamic quality operating in definite directions. Ascertaining this direction is called "vector analysis." In the investigation of psychosomatic disturbances, vector analysis is of great value. This had been demonstrated, for instance, in the study of gastric disturbances. The stomach functions can be disturbed by different emotions having the same dynamic direction: the wish to receive help or love, or the wish aggressively to take something away. The same group of wishes may also disturb other organic functions which involve incorporation. Incorporation is not limited to swallowing, but may also apply to breathing. Other dynamic qualities of similar importance are the retentive and eliminative tendencies. The equilibrium among these three fundamental urges—incorporation, elimination, retention—represents the dynamics of the biological process called "life."

The application of psychoanalysis as a distinct method of research has proven its effectiveness in a number of organic conditions. One of the first clinical syndromes investigated by Franz Alexander and his co-workers of the Chicago Institute was hypertension. Increased blood pressure as a normal response to rage is a utilitarian reaction of the organism, preparing it and making it fit for flight or fight. In the case of the hypertensive patient, the normal discharge does not take place because of a paralysis of the emotions. Neither the passive, dependent attitude nor the hostile impulses may be expressed freely, but the two opposing emotional attitudes block each other. Social life today requires

an extreme control of hostile impulses and this may be the reason for the increased frequency of hypertension. Constantly inhibited rage may lead to a chronic elevation of the blood pressure. Analysis may help to solve the pronounced conflict between passive, dependent, feminine, receptive defenses and over-compensatory competitive, aggressive, hostile impulses which lead to fear and increased flight from competition to the passive, dependent attitude.

In cases of essential hypertension, the following similarities were found by psychoanalytic investigation:

1. The prominence in every case of a dominating mother with submissiveness and oral dependence toward her; unsuccessful, nearly conscious rebellion against this submissiveness; and chronic unexpressed rage at unsatisfied oral demands and at independent activity and work.
2. Marked inhibition of heterosexuality, although indulged to some extent despite anxiety.
3. Intense, chronic, inhibited hostilities not adequately repressed and bound, as with cases of organic neurosis.
4. The hypertensive individuals were neither weak and dependent nor aggressively hostile, but were blocked in both directions. During periods when either trend was satisfied, the blood pressure was markedly lower.

The study of patients with coronary occlusions showed similar conditions. Jacob A. Arlow found that the personality of the coronary patient offers the individual little happiness and solves few of his problems in a satisfactory manner. The compulsive striving for achievement and mastery never seems to end. Success does not bring with it a sense of gratification or relief from tension. The individual is constantly drawn into new situations where he recreates the original situation of competition, a situation which he attempted to master by identifying with his superior. Neither in the psychic nor in the somatic sphere is the

patient ever at peace. The focal conflict with authority cannot be said to have been repressed successfully. Identification with a feared and envied parent has not solved the problem. As Dunbar stated: "Coronary patients are remarkable in the apparent strength and extreme brittleness of their defenses."

Following the research into the problem of high blood pressure, the gastro-intestinal syndromes were made the subject of psychoanalytic research. The findings were published by the Chicago Institute for Psychoanalysis in a symposium, *The Influence of Psychologic Factors upon Gastrointestinal Disturbances*.^{*} The most conspicuous features in the psychoanalysis of gastric cases (three gastric neuroses and nine duodenal ulcers) are intense receptive and acquisitive wishes against which the patient fights because they are connected with extreme conflict in the form of guilt and inferiority feelings. The psychoanalytic investigation of these cases may be summarized with the slogan, "I do not want to take or to receive; I am active and efficient and have no such wishes." In some of the cases the receptive wishes are not inhibited internally but by external circumstances.

The psychoanalytic formula of the five studied colitis cases is: "I have the right to take and demand for I always give sufficiently. I do not need to feel inferior or guilty for my desires to take because I am giving something in exchange for it." The diarrhea serves as a substitute for giving of real values.

In the five analyzed constipation cases, the dynamic background of the symptom may be verbalized as follows: "I do not take or receive and therefore I do not need to give." The constipation is a reaction to the obligation to give, and is linked with the fear of castration.

The gastrointestinal tract, according to its three major functions of taking in, retaining, and eliminating, is a suitable vehicle for the expression of these three elementary tendencies when

^{*} Reprinted in "Psychosomatic Studies"

their normal expression through the voluntary motor system or the sex apparatus is inhibited through inner conflicts. The upper end of the tract is well fitted to express the receptive or taking tendencies, whereas the lower end is more suitable for the expression of giving and retentive tendencies. Intaking may be passive, receiving, or an aggressive taking, and also eliminating may be a loving gift or an aggressive attack. This symposium is a basic keystone in the building of modern psychosomatic medicine—a summary of the first practical results, a unique proof of psychoanalytic group work, and a masterly example of the methodological approach of psychoanalysis in the field of psychosomatic medicine.

Early in the history of analytic research Edwardo Weiss analyzed a case of asthma (1922). This work is of theoretical and practical importance because in his analytic study of one case, Edwardo Weiss could outline most of the findings which later were established in broader fields of analytic experience. He demonstrated that analytic research if correctly applied can be taken as valid proof for the establishment of psychodynamics in one patient or in a group of patients. Twenty years later Thomas French and his associates confirmed the findings of Edwardo Weiss and enlarged upon them. The emotional conflict of the asthmatic centers about his repressed desire for love from the mother. The analysis of asthma patients reveals again and again a conflict between aggressive masculine and passive feminine tendencies. The asthma attack represents the repressed cry of the new-born child for his mother.

Analytic research of the emotional conflict leading to diabetes mellitus is only in the beginning. Among other investigators, Daniels, Bollmeyer, Meyer and Alexander have given preliminary reports on two cases of diabetes mellitus—in a man and a woman—who both developed their illness under the strain of an emotional conflict of striking similarity. Both subjects showed

unusually strong tendencies to receive and to be taken care of. The first patient's essential demands were stimulated by a physical trauma at the end of his weaning period; the second patient's by a traumatic weaning process. Both patients retained an infantile dependent and demanding attitude. They felt frustrated because their demands for attention and love were out of proportion to the reality situation of an adult and consequently were never adequately satisfied. To this frustration both patients reacted with hostility. Diabetes developed in both cases when these infantile wishes were frustrated, and the sugar output decreased when they temporarily renounced their demanding attitudes. It seems probable that these food-demanding drives, if nobody is there to satisfy them externally, may turn to an autoplasmic satisfaction in a metabolic process which mobilizes glucose out of the glycogen stores of the body. The observation of increased sugar output during the night, i.e., independent of the carbohydrate intake, under these emotional conditions, is consistent with these assumptions. The interpretation is in conformity with recent experimental findings, namely, that in certain cases of diabetes mellitus the rise of the sugar level is dependent not on failure of sugar utilization but on sugar mobilization. Both patients were under analysis for two years and during that period they underwent careful clinical observation including four to six sugar tests daily. One patient was found free of sugar for five years subsequent to the end of his analysis. The author's research marks a hopeful start in the psychosomatic understanding of diabetes.

The most recent psychoanalytic research concerns the study of arthritis. This research is only beginning and no definite conclusions can be reported. However, the Chicago Institute under the supervision of Franz Alexander, studied thirty-three cases of rheumatoid arthritis. It was found that the women patients had a marked tendency toward bodily activity, an inclination toward

outdoor sports, and they showed a strong control of all emotional expression. Their dependence upon other persons was overtly masochistic in character. To their children they were demanding and exacting. So far as sexuality is concerned, they rejected the feminine role, showed masculine protest reaction, competed with men, and could not submit. Their husbands were usually passive men, frequently with physical defects.

As precipitating events it was found that unconscious rebellion and resentment against men activated the disease. It also seems that in situations where self sacrifice and service to others does not succeed in keeping guilt feelings satisfied, the disease breaks out anew. A third situation arises when masculine protest reaction was intensified in order to serve as a defense against fear of sexual attack.

In deeper analytic material, the masculine identification appears at times through the utilization of the neck or limbs or of the whole body as phallic symbols. This identification always has a hostile connotation and is often linked with castrative impulses both in the form of grabbing with the hands and of oral incorporation.

As far as the infantile background is concerned, these patients usually have a strong, domineering, demanding mother, and a gentle, compliant father. The relationship with the mother is the source of their intense masochism; the female role becomes frightening for them at the oedipal period. In their oral aggressive attitude toward the cold and rejecting mothers lies the earliest basis of the later grasping, aggressive attitude toward men.

Arthritic patients are somewhat similar to hysterical persons with chronic, hostile, aggressive impulses and their compulsive defenses. At one end are those cases in which aggression and defense against attack are handled by discharge into somatic conversion with a symbolic expression of ideational content. In

all gradations to the other end of the series we find those cases where the ego-syntonic discharge of chronic, inhibited hostility through muscle activity, hard work, and sports has been interrupted and there develops an increased general muscle tonus which may precipitate an arthritic attack. In other words, the patients learn to discharge aggression through activity, as for instance, hard work, sports, gardening, etc. They live in a psychologic straight-jacket through which they hope to achieve equilibrium between aggressive impulses and control.

This report has not attempted to give a full outline of psychosomatic medicine. Only illustrations were chosen so far as symptoms are concerned and also so far as the workers in the field are concerned. Work has been done, for instance, in polysurgery, urinary disease, in the vast field of gynecology and especially obstetrics, in the still unknown problems of cardiology, especially the ever-increasing number of angina pectoris cases. Of special interest and therapeutic hopefulness are the recently reported cases on dermatology and allergy, with their numerous manifestations.

The field of psychosomatic medicine insofar as it teaches psychotherapy, is mentioned here because it may form a cross-road in further development. It can be assumed that psychotherapy will develop into three branches; first, psychosomatic medicine, as a domain for the physician trained in psychological medicine; second, psychoanalytic psychotherapy in all its modifications applied to the broad field of psychiatry, especially psychotics and other patients in need of hospitalization; and thirdly, a field of psychotherapy which covers an enormous group of borderline cases.

The third branch could be visualized as a future possibility of psycho-therapy growing out of psychoanalysis, but combined with the methods of social work, vocational guidance, child care, and even academic psychology. All three branches would have

principles of psychoanalysis and analytic technique in common, but by adjusting them to the special needs of their field of operation and frame of references, they would develop as branches of analytic therapy. Such progress will decide whether this third domain is going to remain an exclusive field for the physician only or whether a new specialist trained in psychoanalysis and some of the above mentioned specialties will develop into a psychoanalytic therapist without medical background. At the present time such separation cannot and should not be made (Martin Grotjahn).

B. Recent Advances in the Psychotherapy of Psychotics

A growing interest in the psychotherapy of the psychoses has been manifest of late, stimulated by the encouraging therapeutic results reported recently by a number of investigators who have applied psychoanalytic principles in the treatment of psychotics. These developments have reversed the earlier attitude of psychoanalysis. This skeptical view was promulgated by Freud himself. In *The Introductory Lectures* he stated: "Experience shows that persons suffering from the narcissistic neuroses have no capacity for transference, or only insufficient remnants of it. They turn from the physician, not in hostility, but in indifference . . . the process of cure which can be carried through with others . . . cannot be effected with them. They remain as they are." Earlier Abraham asserted: "In attempting to psychoanalyze them (dementia praecox patients) we notice the absence of transference again. Hence psychoanalysis hardly comes into consideration as a therapeutic procedure in this kind of illness." Almost to the last Freud adhered to this pessimistic opinion. In *The New Introductory Lectures* he wrote: "the field in which analytical therapy can be applied is that of the transference neuroses. Everything other than these, such as narcissistic psychotic conditions, is more or less unsuitable."

Notwithstanding this unyielding therapeutic pessimism, it was Freud who provided the groundwork for the analytic understanding of psychotic processes. A first attempt at elucidating the essential process in schizophrenia was made by K. Abraham in 1908 in his paper "The Psychosexual Difference between Hysteria and Dementia Praecox." Abraham arrived at the view that "The psychosexual characteristic of dementia praecox is the return of the patient to autoeroticism . . . this illness involves cessation of object love and sublimation." Three years later, in 1911, Freud's study of the Schreber case appeared, which marked a milestone in our insight into the psychotic mechanisms. In that paper, which was based on the analysis of an autobiography of a paranoid schizophrenic, Freud demonstrated that the fundamental process in the development of a psychosis is a withdrawal of libido from objects and its investment in the ego. This amounts to a regression from the stage of object-love to that of primary narcissism. The process proceeds silently, out of view of the observer, and finds symbolic expression in the form of a fantasy of 'the end of the world.' Once the libido is withdrawn from objects, the world is emptied of all interest and it appears desolate, as if utterly destroyed. The detached libido is withdrawn into its reservoir in the ego, resulting in the reestablishment of the infantile megalomania, with the appearance of delusions of grandeur. Some of the freed object libido accumulates in various organs. These hypercathected organs become the source of displeasurable tensions and give rise to hypochondriasis. The process of libido withdrawal results in a break with reality, with a consequent loss of reality testing, a loss of ego boundaries, a general primitivization of the ego, and an increased libido cathexis of the patient's body.

Side by side with the process of regression, or soon after its consummation, a tendency operating in the contrary direction asserts itself. This is the process of restitution, aiming at the

regaining of the lost objects. The psychological mechanism of projection is utilized for this purpose. The relationship reestablished with objects tends to assume a hostile character, as is apparent from the hallucinations and delusions which most often have an unpleasant tone. Catatonic symptoms also have been shown to be attempts at clinging to objects that are slipping away, or at regaining lost objects (Tausk, Nunberg, Jung). Thus Freud showed that what had previously been regarded as the primary feature of the psychosis is actually a manifestation of a reparative process.

Freud further demonstrated that the conflict which produces the profound regression, at least in the case of the paranoid form of the disease, rages around intensified unconscious homosexual strivings. The patient defends himself against these unacceptable temptations by a process of denial and projection. When those defenses prove inadequate, regression to a point of fixation at the narcissistic stage ensues.

The influences which produce the original fixation remains obscure. It is thought to be compounded of organic disposition and traumata that occurred in the early phase before object relationships were definitely established. F. Fromm-Reichman, J. N. Rosen, and others attribute the early warping to rejection during infancy by one or both parents.

Some light has been thrown by a number of investigators on the nature of the process of libido withdrawal and its later reinvestment. It is essentially a process of incorporation, whereby the incorporated object becomes a part of the ego and ceases to exist as such. When the object is subsequently reprojected it displays many of the features of the ego, thus testifying to its 'passage through the ego.' According to Abraham the incorporation occurs by way of the anus. "To the paranoic, therefore, the love-object is equivalent to feces which he cannot get rid of." Staerke and Van Ophuijsen demonstrated that the persecutor is

perceived in the patient's unconscious as his own feces. Incorporation can occur not alone by way of the anus but also by oral, epidermal and respiratory routes. Nunberg observed in his patient incorporation fantasies of eating the therapist or being eaten by him, of inhaling him or being inhaled by him. The incorporation of the object by whatever route results in the destruction of the object, with consequent loss of external reality and of the ego boundaries. Ego and non-ego become one and the patient is back in the primitive infantile state before the ego has become differentiated from its environment. The way back from the regression takes place via projection, by which means the distance between subject and object is reestablished.

While some crystallization of views on the psychodynamics of schizophrenia has thus been arrived at, the same cannot be said about the guiding principles in therapy. No generally-accepted tenets of psychotherapeutic procedure have as yet been established and every therapist develops his own style and approach. Therefore, the description of the therapy of schizophrenia must of necessity resolve itself into a presentation of the views and procedures advocated by the more prominent workers in the field.

Paul Federn devoted a lifetime to work with psychotics and he has formulated his method and experience in a series of papers. The central pillar of Federn's psychotherapy is re-repression of the unconscious material that invaded the ego's realm. Paraphrasing Freud, he expresses this concept in the aphorism: "What has become the Ego's territory should be returned to the Id." Not the entire ego of the psychotic has succumbed to the schizophrenic process; therefore the deficient parts of the ego may be repaired with the aid of those parts that still function with sharp distinction between thought and reality. To assist the repression of unconscious material, the therapist should focus the

patient's attention on the conflicts that arise from his current life situation which activated the buried unconscious conflicts and precipitated the psychosis. The patient usually tends to ignore the reality conflicts and fails to perceive their connection with the unconscious ones. When this connection is made clear to the patient, it becomes easier for him to turn away from the more infantile ego-states.

To avoid encouraging regression to infantile ego-states, free-association should not be employed. It tends to produce manic flight of thought and increases guilt feelings with resultant depression. The patient should not be made to lie on the couch like other analytic patients, and even an anamnesis should not be taken from him. Federn gives these admonitions: "Do not provoke; do not be active; do not try too vigorously to elucidate the basic conflict. . . . A psychoanalysis with daily sessions, strict rules, and, incidentally, high costs is not indicated."

The main lever at the disposal of the therapist for lifting the patient out of his psychosis is the positive transference. Transference operates by counteracting narcissistic withdrawal and increasing object interest. "To the patient, transference as well as identification are gratifying and pleasurable conditions." Contrary to the procedure with neurotics, the transference with psychotics should not be analyzed and dissolved, but carefully nurtured, managed and protected. A positive transference should be fostered and preserved and one must be on guard against provoking a negative transference reaction. During a negative transference phase analytic treatment cannot be continued. "The psychiatrist must preserve the positive transference by siding with the patient in any of his conflicts." Once a good relationship between therapist and patient is established, a cautious attempt may be made to rectify the falsifications of reality. This should not be done by criticizing the patient's productions but by merely juxtaposing the correct view of reality.

Federn advocates that the therapist enlist the assistance of a motherly figure in managing a psychotic patient. This may be a close relative or nurse who can give the patient the love he needs. "A good result in an advanced psychotic cannot be achieved without the help of a motherly nurse." The rationale for this stipulation is that the psychotic is more dependent on reality in the transference situation than the neurotic. If the psychotic transfers his mother relationship to a male analyst, he easily confuses homo and heterosexual feelings and becomes more disturbed. In addition to the maternal helper, it is important for good results that the patient be in a favorable life situation, which provides material security and a source of sexual gratification.

Frieda Fromm-Reichman has had an extensive experience over many years in the treatment of hospitalized psychotics. She was deeply impressed with the schizophrenic's sensitivity in interpersonal relationships and his insatiable craving for affection and acceptance. This sensitivity stems from the schizophrenic's fear of a repetition of the pathogenic rejection which he suffered in infancy at the hands of his mother, as well as from his fear of his own retaliative hostility, which fills him with anxiety. To deal with this sensitivity and distrust, Fromm-Reichman erected love and patience as the cardinal attitudes in therapy. She strove to be as permissive as possible, taking extreme precautions to prevent hostile reactions on the part of the patient, even to the extent, for example, of allowing a patient to smear her dress with feces. She was also cautious not to give interpretations until she felt sure that the patient was ready for them. All these precautions were intended to forestall a complete break up of the therapeutic relationship, which seemed an ever-threatening eventuality in view of the very intense ambivalent and labile transference that the psychotic develops toward his therapist.

Subsequent experience convinced Fromm-Reichman that this over-cautious attitude, far from safeguarding the treatment, fre-

quently hindered it. The excessive caution resulted in a loss of spontaneity on the part of the therapist which was more detrimental than any mistake in interpretation or even undue arousal of anxiety in the patient. K. Eissler also pointed out that excessive permissiveness in the treatment of a psychotic is undesirable, for it may drive the patient into a deeper withdrawal. R. Knight found that his therapy of a catatonic youth made no progress until he changed his completely permissive attitude to a firm, protective one. He concluded that too great indulgence leaves the psychotic at the mercy of his primitive urges and anxiety. Fromm-Reichman re-stated her position as follows: "While it is most undesirable for the psychiatrist to create additional frustrations in a thwarted psychotic life, he cannot undo the evil consequences of the past merely by safeguarding against their repetition. The evil influences of the past have to be counteracted by recollection, 'working-through,' reevaluation and integration of what happened in early life in terms of the present."

Fromm-Reichman used to be rather sparing in her interpretations. She believes that the schizophrenic is already largely aware of the unconscious meaning of his mental productions and that, therefore, interpretation of content has a limited usefulness. The "main goal should be helping the patient to become aware of the genetics and dynamics of his disturbance." She, therefore, interprets the psychotic symptoms mainly as defense, attempting to demonstrate to the patient the purpose they serve him and his motives for employing them.

Fromm-Reichman, like Federn, finds the usual technical requirements of psychoanalytic treatment inapplicable to psychotic patients. The "couch-regulation," the "victrola-record" attitude of the therapist, "free association," regular one-hourly periods of interviews—all these are neither understood nor followed by the psychotic. Direct questioning may be resorted to, and length

and frequency of interviews should be regulated by the requirements of the patient at any given time.

An important innovation in the therapy of schizophrenia was introduced by John N. Rosen with the appearance of his paper, "A Method of Resolving Acute Catatonic Excitement," in 1946. It was a report of the successful termination of acute catatonic excitement in seven patients by means of psychotherapy, after all physical measures failed. The following year Rosen published another report, "The Treatment of Schizophrenic Psychosis by Direct Analytic Therapy," describing the apparently successful treatment of thirty-seven cases of long-standing schizophrenia with the same psychotherapeutic method. It marked the first time that so large a group of psychotic patients treated by a particular psychotherapeutic method had been reported.

Rosen's method was anticipated in the work with psychotics reported by Martin Grotjahn in 1938. According to Grotjahn, the first task that confronts the therapist who wishes to treat a psychotic is to establish contact. Since the psychotic is enmeshed in his narcissism as a dreamer is in his dream, the usual means of communication are ineffectual. The analyst is, therefore, compelled to communicate with the patient on his own level. To that end, Grotjahn attempted by the exercise of his fantasy to produce "hallucinations" to parallel those of his patient who hallucinated continually during interviews. For the first time, the patient began to listen; an intense transference developed and by means of it the patient was helped to reestablish a good relationship with the outer world. In another case, communication was established by the analyst acting out the role of the patient, while the patient was invited and permitted to assume the therapist's role. Grotjahn explained his method in the following words: "Nearly everything that the analyst avoids in the analysis of adults he must employ in the analysis of psychotic persons and children. He must play their game with them. He must speak

their language, dream their dreams, in order to establish communication with them by any means, and actively to create the proper transference situation. . . . Interpretation has to be "deep" interpretation of the content, has to be a series of "long shots in the dark." . . . Such a "deep," surprising, and shocking interpretation as a proof of understanding and established communication strengthens the relation between the patient and analyst."

Rosen's therapeutic method has been designated "direct analysis" because it consists of a direct, uninhibited interpretation of the patient's unconscious productions and symptomatic acts. The therapist joins the patient on the level of his psychosis, sharing with him his psychotic reality which is peopled with magical infantile figures. The therapist endeavors to personify these images as they are revealed in the patient's hallucinations and convert them from terrifying, threatening figures into benevolent, protecting ones. These the patient projects upon the therapist, establishing a strong positive transference, which then becomes a bridge to reality. Although of necessity many of the interpretations given are incorrect, they do not seem to do any harm; whereas the correct interpretations make a profound impression on the patient. Thus the main tools in this therapy, as in any other psychoanalytic type of therapy, are the transference and the dynamic interpretation.

Rosen does not confine himself merely to interpretation; he *acts* the good parent as well. He believes that the physician who treats a schizophrenic "must make up for the tremendous deficit of love experienced in the patient's life." While treating the patients in catatonic excitement, he stayed with them as long as ten hours at a stretch, nursing and caring for them with indefatigable solicitude. In response to requests from his other patients, he would go for walks with them or accompany them on shopping tours. Rosen seems to have an extraordinary capacity for

tolerating all manifestations of negative transference. On at least three different occasions his life was seriously threatened by patients, without materially shaking his "inner security." J. Eisenbud, who watched Rosen with his patients, stated: "I don't believe that there are many people who could approach the psychotic with the complete absence of fear, the complete absence of hostility, the identification without the need to shuttle back and forth frequently to a safety zone, that characterizes Dr. Rosen's approach."

In comparing the different therapeutic approaches outlined here, points of general agreement as well as of disagreement become evident. All therapists agree that, contrary to the earlier view, the psychotic is capable of making a transference if properly approached; that the transference is likely to become an intense one, and to be characterized by strong ambivalence and lability; and that in the improvement of the patient, the transference plays a preeminent role. With respect to interpretations, however, there appears to be rather wide divergence of opinion. Federn stresses that reality must be interpreted rather than the unconscious; Fromm-Reichman holds that it is useless to interpret since the schizophrenic knows his unconscious better than the therapist; while Rosen insists on interpreting the unconscious meaning of all symptoms and psychotic products to the deepest level. S. D. Lipton has attempted to reconcile the apparent divergence of views by calling attention to the fact that the disagreement stems from a difference in the type of case treated. "In incipient, early, or borderline schizophrenics, those who are not as a rule institutionalized, it is commonly accepted that it is inadvisable to make interpretations of unconscious material against which the patient is defending himself. . . . It would appear that the so-called direct or deep interpretations of the unconscious are safely applicable only to overtly psychotic patients." When it comes to a consideration of the attitude of

the therapist to the patient, the so-called counter-transference, variations in approach become apparent. It is generally accepted that the schizophrenic seeks and needs a maternal transference. Federn maintains that the male therapist cannot and ought not himself provide that transference; for that purpose the aid of a motherly nurse should be enlisted. Ernest Simmel, in his Berlin sanatorium, the first of its kind to be run on psychoanalytic lines, organized his entire staff to provide the supportive maternal care institutionalized psychiatric patients require. Fromm-Reichman and others implicitly provide the maternal attitude by insistence on patience, permissiveness and protectiveness toward the patient. Presumably this attitude may be easier for a woman to assume than for a man. However, Rosen says he feels like a parent to his patients, and in return his patients probably find it easier to develop a maternal transference to him. It seems likely that Rosen's unambivalent maternal attitude, plus the strong positive transference that patients can develop toward him and he to them, constitute the most significant factors in the spectacular success of Rosen's therapy (Sig. Gabe; Martin Grotjahn).

E. Recent Advances in the Development of Psychotherapeutic Technique

As has been pointed out, Freud's most important therapeutic instrument was the development of the transference neurosis in the patient, and its use in the analysis of the resistance against the interpretation of the unconscious through the method of free association. According to analytic theory the neurotic conflict remains unconscious; some instinctual drives cannot be accepted by the patient's consciousness—are repressed into the unconscious and kept there by a continuous effort. To maintain this effect of repression the ego is drained of a part of its energy which otherwise would have been used to carry on its more pro-

ductive functions. These functions aim at the person's adjustment to reality. The constant drain of psychic energy for the purpose of repression causes a neurotic patient to be no longer as efficient and as happy as he has been before the onset of his neurosis, or as he could be according to his potentialities.

In a later state "the repressed returns." This means that the repressed tendencies express themselves anyhow. They may cause anxiety or by compromise with the superego may become acceptable to the ego in disguised form, and thus constitute a neurotic symptom. The symptom, in other words, is the compromise formation between the repressing ego (supported by the superego or conscience) and the Id, which is the reservoir of the instinctual drives. Under the camouflage of a symbolic expression and with the feeling of suffering, the wish-fulfillment of the drive finally finds a partial and indirect "ego-syntonic" outlet.

In analytic therapy the patient is asked to lie down and to try to relax and say what comes to his mind, not to select material nor to judge it, to listen to things he does not want to say with a special kind of tolerance, to formulate in words his thoughts, feelings and physical sensations. During the treatment a transference neurosis develops in which the patient transfers the feelings and experiences of his infantile past to his analyst. With the help of this phenomenon and its careful and consistent interpretation the etiology of the neurotic symptom that has been repressed in the unconscious can be discovered and understood. The patient's ego can integrate the new insight, when freed from the constant effort to keep the forbidden wishes down, and can make a new and free start towards growth and maturity. In other words, the ego can integrate the instinctual energies which keep psychic life going. The ego aims at a harmonious cooperation between super-ego, Id and outerworld. Repression is mentally wasteful and unhealthy, because it drains psychic energy from free development. Tendencies unacceptable to our ego can be

handled more economically than by repression, as for instance, by sublimation or reaction formation.

The analysis of the transference becomes the basis of analytic therapy. The search for forgotten memories from the past, the reconstruction of the patient's history, cathartic experiences, have moved into the background but are still important for analytic therapy; intellectual insight, emotional maturation as manifestations of prolonged ego training have moved into the foreground.

Mastery of an old unresolved conflict becomes possible because in the treatment the intensity of the transference conflict is less than the original conflict. Furthermore, the therapist assumes a different attitude from that of the parent in the conflict situation. The more precisely the therapist is able to revive the original emotional situation in the transference and the more precisely he can provide by his own attitude towards the patient the necessary "corrective emotional experience," the more profound and speedy will be the therapeutic result.

Under the pressure of ever increasing demand for psychiatric help, psychiatrists and psychoanalysts in recent years have looked for increased efficiency in psychological treatment. It is not only the pressure of our times which has induced psychiatrists to look for more efficient and less time-consuming methods. It is also true that psychoanalysis is coming of age. With increased experience it might be possible to look for increased therapeutic efficiency.

In the beginning of psychoanalysis it was almost an unavoidable necessity to discover and rediscover the existence of the unconscious, the dynamics of dreams, the meaning of transference, the use of interpretation in every patient. It is time to apply our knowledge acquired over the course of years in more efficient ways of treatment. It is also true that aside from the increased knowledge of psychoanalysis by the specialists, the

general public is less resistant to the psychological approach. This does not mean that the true resistance of the suffering patient against uncovering of his unconscious is changed. It only means that the psychological atmosphere of our time and the tolerance for psychological interpretation has changed within the last fifty years. Many psychological interpretations which could not be voiced and be accepted, are almost self-evident now. This gives the therapist a distinct advantage of which he is frequently no longer fully aware.

Here arises the question of where psychoanalysis is indicated and where shorter methods of treatment may be justified. Increasing experience with briefer methods has shown that this is a misleading question. The therapist will begin treatment by sitting down with his patient and "look for a way out" or "a new start." If he holds to the few principal rules of psychoanalysis, which concern the analysis of transference, the interpretation of the resistance and the liberation and integration of the repressed drives, he sometimes will develop the treatment according to what is generally called "the standard method of psychoanalysis."

The same therapist will feel free to modify his approach according to the necessities of the unique and constantly changing psychological situation. In this respect modern psychotherapists are more flexible than they used to be. The skeptical therapist will keep in mind that the symptoms he has to deal with are the outcome of many years of faulty development. It would be a sign of the therapist's conceit if he thought that he could analyze or change a person's character which grew over many years within a few hours. Even under favorable conditions the process of maturation will take considerable time.

Occasionally it may be advisable to interrupt the psychotherapy in order to give the patient a chance to continue this process of maturation by himself outside of the analyst's office

and away from the analyst's couch. The process of *working through* and integrating the therapy as an emotional experience, and as a starting point for new achievements does not have to take place necessarily on the couch. It may be continued in intervals free of psychotherapeutic interviews and interference. This has been known to experienced analysts as episodes of "germination," but has been employed systematically only recently. It happens frequently that treatment which is continued after such interruption is more successful, rather than that such interruption terminates the treatment prematurely. It is a frequent experience that in cases where the therapist does not see fit to interrupt the process of working through, it takes as much time in therapy as it would have taken without such therapy. As in any question of technique, however, interruption or no interruption can be used as methods of hiding in a state of resistance. This resistance is not necessarily on the side of the patient only. The analyst always has to look into his own conscious and unconscious motivation also, and the resistance about continuation or interruption by the patient is often responded to by the analyst in his own counter-resistance. Here again it is the flexibility of the method and the adjustability of the therapist which will determine the right decision.

One of the places where analytic technique has been investigated with great care, and where briefer methods of analytic principle have been studied and tried is the Chicago Institute for Psychoanalysis, under the leadership of Franz Alexander. The new research was started again under the pressure of necessity. One of us (Martin Grotjahn) was working for years in the out-patient department of the Institute in Berlin and later in Chicago; he was always struck by the necessity of helping "out-patients" and being unable to guide them into being accepted by psychoanalysts for psychoanalysis. There was in the community a great need for briefer methods, and over the years

Martin Grotjahn collected 250 such cases and reported about them. Later the Chicago Institute for Psychoanalysis published these and other cases with the theoretical conclusions in their book *Psychoanalytic Therapy*.²⁰

In this study the Chicago group of psychoanalysts challenged "a number of customary but never substantiated" assumptions which those who practice the standard psychoanalytic procedure take for granted. "These Assumptions are: that the treatment, if it should be considered psychoanalytic . . . must be (1) necessarily prolonged over many months—seldom under a year, (2) that it must consist in daily interviews, (3) that it must be passive, the analyst following the patient's spontaneous self-revelations and as much as possible, avoiding interference with the patient's daily life; and finally, (4) that infantile amnesia must be lifted and the patient must acquire a conceptual understanding of the genesis of his difficulties." (Proceedings of the Third Psychotherapeutic Council). Franz Alexander credits Ferenczi with being the first to question some of these therapeutic assumptions. Ferenczi denied that the recovery of forgotten traumatic events is essential, as Freud believed. Instead, he maintained that it is the transference relationship that is crucial for therapy. Alexander carried Ferenczi's thought a step further by demonstrating that the recovery of memories is but an indicator of progress already achieved through the mastery in the transference relationship of a previously unbearable conflict.

The emphasis of analytic therapy has shifted in the following ways: (1) The basic requirement of any rational psychotherapy is the understanding of the emotional conflict of the patient. Previous analytic knowledge, training and experience, may possibly be used to shorten the time of the treatment which is necessary to orient the analyst about the patient's psychodynamic development. It is possible that the general psychiatric and psychoanalytic atmosphere of our time, so much more favorable

than fifty years ago, can shorten the search for the clues in the understanding of the patient. (2) The second point of emphasis is the "corrective emotional experience." The efficiency of psychoanalytic therapy may be increased by exposing the patient in a planned manner to emotional experiences suitable to undo the effect of the pathogenic experiences on him. It is of secondary consideration whether these corrective experiences take place in the transference situation or in daily life; in relation to the therapist or to other persons. Since only the therapeutic experiences are controllable, they constitute the axis of the therapy. The daily experiences of the patient can be utilized frequently in a planned manner. All these therapeutic principles have been implicit in the theory of psychoanalytic therapy since the time that the transference was recognized as the dynamic core of the treatment. The objective attitude of the therapist constitutes the most available means of providing corrective emotional experience for the patient and as such it is a powerful therapeutic factor. The therapeutic situation is a unique one; it deviates from all other interpersonal situations in its objectivity. (3) the third point concerns planned treatment, and is described by Thomas French in detail in his chapter of the book *Psychoanalytic Therapy*.²⁰

Summarizing, we can outline the different stages of development of analytic therapy as follows: Cathartic hypnosis, Waking suggestion, Free Associations, Symbol Analysis, Transference Neurosis, and Resistance Interpretation. Features of all these previous developmental stages in analytic technique have been taken over into the next step and are all represented in this stage, which could be characterized by Alexander's term "emotional re-education." In this form of psychoanalytic therapy the emphasis is based on Ego-synthesis, reality adjustment, corrective emotional experience and planned treatment. In a negative way it can be characterized as an avoidance of regressive states

within the framework of the transference neurosis. It must be kept in mind, however, that even analysts in previous times realized that only a certain amount of regression is necessary, and that regression, too, like any other psychological phenomenon can be used as a method of resistance.

The greatest difference between the previous and the last stages of analytic development concerns this question of therapeutic regression. In the "planned treatment" where the therapist is flexible enough to change the number of interviews, frequency of visits within the time unit, interruptions for longer periods, a mechanical device is used to avoid the danger of using regression as a form of resistance against adjusting to reality. The analytic situation of free association and lying down on the couch can frequently be used by the resistive patient to escape back to the early pre-traumatic, highly dependent emotional state in which the patient felt safe and contented. Regressive material is not necessarily a sign of the depth of the analysis, but frequently a sign of the extent to which the ego withdraws from reality as a threatening situation. Here again a shift of emphasis takes place. Even in the standard forms of psychoanalysis the analyst will watch out for such regressive developments. The more skillfully and the more correctly a treatment is conducted according to principal analytic rules, the less time will be spent with regressive material. There always will be time for a healthy amount of such regression in order to safeguard true work in the unconscious.

The fine details of controversy can not be discussed here, where only main features of development are outlined. It must be stated, however, that the properly conducted analytic psychotherapy is not a fillibuster, has nothing to do with procrastination, is not necessarily prolonged, and does not let the patient slide into an unanalyzable dependency.

To our knowledge it is not yet possible to shorten pregnancy

and it looks as if the little embryo on his way to become a person has to go through rather "regressive states" of development. Future research will show how much regression to infantile stages during a thorough analysis is therapeutically necessary. Theoretically the answer is easy and can serve as a guidepost for therapy; there, where regressive material—such as a flood of dreams, uncontrollable wealth of early recollections, the acting out of infantile impulses, the appearance of highly dependent passive behavior—in other words, where such regressive material is used as a resistance in psychoanalysis, it must be treated as such and not taken as unavoidable or even desirable.

Quite generally it must be pointed out that specific research in methods of psychotherapy is still in its beginning. The therapist's first obligation is directed toward his patient and towards helping him. While treatment is still in progress, the therapist has a hard time to free himself from the pressure of his therapeutic obligations and even after he has finished therapy, he still feels this obligation, which often interferes with an objective description of the treatment. How the treatment really took place is colored by his therapeutic ambitions. The evaluation of results has little to do with the description of therapeutic technique and procedures. To find methods of scientific investigation of psychotherapeutic technique is one of the most important tasks of present-day research in psychotherapy (Martin Grotjahn).

On Group Psychotherapy

Recently, and especially during the war years, much work has been done in the study and use of group psychotherapy. It was tested before the war by Moreno, who coined the term "psychodrama," and by Paul Schilder and Louis Wender, who reported on therapeutic work with groups. Since the war, numerous reports from workers in the field have appeared, indicating that

the interest in group psychotherapy has carried over from war-time into peace-time use.

Group psychotherapy was born out of an emergency situation, out of the disproportion between the number of patients and psychiatrists. Patients could not be seen often and treated intensively in individual interviews but had to be seen in groups. Group psychotherapy has outgrown its character as an emergency measure and is acquiring its own rights and functions within psychiatry. Martin Grotjahn, in a report of his experience with group psychotherapy, states that the time has not yet arrived to formulate in terms of psychodynamics what actually goes on during group psychotherapy meetings. All that can be done right now is the collecting and reporting of observations and the exchange of opinions.

Group psychotherapy offers emotional support to the members of the group by giving them group status before they have re-established their status as healthy individuals. This group status gives strength and reassurance to the individual. It is expressed in the feeling of belonging with the other group members and in feelings of confidence in the central figure of the group, the therapist.

The group develops a positive transference to the central figure with greater ease than the individual patient. This transference can be used to overcome a part of the resistance towards recovery. This is accomplished by the creation of a therapeutic group-optimism, an esprit de corps. In this respect group psychotherapy accomplishes a reintegration of previously established patterns; more than that, it constitutes a new orientation of the personality structure.

In the group therapy the patient is given a chance for catharsis of anxiety, aggression and guilt without danger to the individual but with intensity enough to be of therapeutic benefit. In the discussions, which almost follow the rule of free association,

defenses can be tested and modified, interpretations can be given and accepted, insight may be gained and unconscious material may come into consciousness. Interpretations may be given as far as both resistance and unconscious contents are concerned. Inherent in the character of the group meeting is the fact that the procedures remain largely on the level of reality testing.

In group psychotherapy an emotional experience of integrated human group relation is felt; at first the group matures as compared with other groups, later the individual improves. The process of socialization is actually experienced in the group meetings by the individual. The traumatic situation of sudden individualization in the beginning of the neurosis is relieved in the relative safety of a new and kinder group.

Nathan Ackerman has arrived at similar conclusions and has listed the six therapeutic aims of group psychiatry as follows: to provide emotional support through group relationships, to encourage discharge of pent-up aggression, to reduce guilt and anxiety, to encourage the correction of irrational interpersonal reactions, to increase the self-esteem and recognition of constructive capacities, and to foster the development of insight. Quite recently, for instance, Francis Powdermaker, Jerome D. Frank, and their co-workers, have shown a new approach to a systematic research into the psychodynamics of group psychotherapy.

F. Outlook: Psychotherapy and the Future

Our time is an episode in history in which great changes take place with great rapidity. We live in a transition period when culture bound by tradition is changing into culture characterized by the necessity of rapid and radical adjustments to changes in reality and environment. With the loss of traditional values, an emotional poverty or emptiness is felt by the individual. The steadying influence of traditional institutionalized symbols is

lost and the new era of technology with undreamed of terrorizing power threatens the lonely individual.

Psychiatry and psychotherapy were well fitted to become the new hope in this era. They combined the rational approach with a promise to fulfill a wish of all times: "happiness" under the trademark of "mental health." In the imagination of the "modern mind," happiness becomes a psychiatric problem, and a streamlined laboratory in the Building of Human Engineering has already found or will soon find the answer. Life is no longer considered an experience to be felt, but a problem to be solved.

Ours is a time in which "by means of men the aims of apes" could be achieved easily and effectively. The times are gone when little men had nothing to fear but fear itself. In our insecurity, we do not allow ourselves anymore to feel and act in terms of humanistic ethics, but like the men in Huxley's *Apes and Essence*, we try to do to our neighbors what we are afraid they soon may do to us.

Knowledge of the unconscious and of human motivation alone cannot but fail to fill the gap between the technical achievements of men and their undeveloped spirits. Psychotherapy must fail if it is expected to function as a religion in the construction of the most modern and frightening version of Utopia. However, psychology will constitute an essential cornerstone in the building of the human society to come. As a true counterpart of humanistic ethics, it will help to make man free of anxiety so that he may mature in the spirit of tolerance and love which cripple so easily under the threat of fear and repression (Martin Grotjahn).

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Chapter III

THE MEANING AND CAUSES OF MENTAL DISEASES

By

SIGMUND GUNDLE, M.D., Psychiatrist

University of Kansas, Lawrence, Kansas

THE MEANING AND CAUSE
OF MENTAL DISEASES

BY
ERNEST CUNDELL, M.D., Psychiatrist
University of Kansas, Lawrence, Kansas

Chapter III

THE MEANING AND CAUSES OF MENTAL DISEASES

By SIGMUND GUNDLE, M.D., Psychiatrist
University of Kansas, Lawrence, Kansas

I. Historical Considerations

The concept of mental illness has undergone many changes throughout the recorded history of mankind. The general philosophy which has characterized each period of history has also been reflected in the approach to the problem of mental illness. Just as magic, religion, and science have historically been the chief methods by which man has attempted to understand his place in the cosmos, so these same methods have been employed in man's effort to understand psychopathology. The history of man's intellectual production has been compared to a fabric woven of three differently colored threads: the black thread of magic, the red thread of religion, and the white thread of science.¹ The historical development of the concept of mental illness might correspondingly be conceived of as a long rope, the first part of which is composed almost wholly of black strands. Gradually, red strands become intertwined, followed by the addition of a few white strands. As the rope lengthens, the black of superstition becomes less conspicuous but does not completely disappear; the red of religion remains striking; while the white of science becomes predominant.

A. The Animistic Period

According to the magic of primitive cultures, a spirit was responsible for anything that happened. The ordinary behavior of human beings was accounted for by the action of good spirits, while abnormal behavior was explained by the presence of evil spirits. In the next phase of cultural development, that of the ancient civilizations, little was added to this concept of mental illness. The theory of demoniac possession continued to prevail. King Saul, in the Old Testament, was cured of his mental disease when the evil spirit departed from him.² The literature of Assyria and Persia, as well as the old Testament contain numerous formulas for driving out the evil spirits which were thought to cause disease. Responsibility for curing these patients rested primarily with the priest.

B. The Grecian Concept

In enlightened Greece, a similar concept was prevalent, as can be seen in the philosophy of Socrates, Plato, and Aristotle.³ Instead of spirits, they believed in the existence of two souls, one rational and the other irrational. When the latter became ill, the person was considered mentally ill. Morbid "Humors," when they reached the irrational soul, (according to Plato) or the heart, (according to Aristotle), were the immediate cause. It is noteworthy that Plato's moralistic philosophy, with its mind over matter dualism, considered ideas to be true realities which could exist outside the body. It, thereby, established the primacy of reason, a point of view which relegated emotions to a lower plane. Hippocrates was a notable exception among his contemporaries in that his keen psychiatric observations and understanding, as well as his excellent clinical judgment, represented real progress. He was the first to become aware that mental disease reflects personality problems and is due to natural causes.

This same viewpoint dominated the Alexandrian school and Galen in Rome. However, they, as well as Hippocrates, still believed in the existence of Humors, and particularly in brain pathology as the immediate cause of mental disease. Despite this progress, the majority of Greek and Roman medical men continued to support some form of religious demonology as the source of mental illness.

C. The Early Christian Concept

The spread of Christianity did not alter this concept materially, though the content of the theory did change somewhat. That which previously had been thought of as evil spirits became the Devil, or occasionally punishment by God. Throughout the early rise of Christianity and the Middle Ages, theology furnished the frame of reference for exorcistic procedures, coaxing the Devil out of the body of a mentally ill person. Many formulas for exorcism have been quoted in the literature of the Middle Ages. Pope Gregory the Great, for example, is reported to have exorcised the Devil out of a Nun, in an effort to cure her mental disease.⁴ The theory of demoniac possession took two forms. One theory held that the devil gained possession of a human being through some stupidity or shortcoming of the individual so that he was not totally to blame for it. Such individuals were treated by exorcism. The other theory, however, was that the person was in league with the Devil. Then, drastic treatment was administered, such as in the case of many of the medieval witchcraft trials.

D. The First Psychiatric Revolution

The sixteenth century saw the beginning of what has been referred to as the first psychiatric revolution. This brought about an important change in the concept of mental illness which continued through the seventeenth and eighteenth centuries. Men like

Vives, Paracelsus, Cornelius Agrippa, and Weyer opposed the previous theories with great courage. Man was conceived as a miniature cosmos, and human behavior was explained in terms of the relationship of man to his fellow men. Following the Reformation, the 18th century with its scepticism brought a gradual rejection of the theological approach to mental illness. It was then that such men as Pinel, Esquirol, William Duke, and Benjamin Rush made some of the earliest scientific contributions in modern times. Gradually psychiatry began to emerge as a scientific discipline, and mental illness became a medical problem. No longer were mentally ill persons looked upon as sinners, but rather as persons suffering from a disease. This point of view is one which even today meets with some resistance but is accepted by the majority of people.

E. The Period of Brain Pathology

In the second part of the 19th century, mental illness assumed a new meaning, and new causes were investigated. This was the period when pathology and bacteriology began to flourish, stimulating a search in that direction for greater understanding of mental diseases. Supernatural spirits and theological concepts became displaced by the new somatogenic viewpoint. A definite brain pathology was looked for and thought to be the cause of mental illness. Griesinger, and later Kraepelin who was his most noted follower, and many other German psychiatrists under Kraepelin's leadership, proceeded on a physiological and clinical basis to develop the theory that psychopathology could be reduced to brain pathology. According to this school of thought, the meaning of mental illness was limited to brain pathology. There are still many followers of this school today in psychiatry who continue their search for specific brain lesions to account for the various mental diseases. However, even in Kraepelin's time, it was recognized that structural brain damage and

physiological-chemical changes in the body could explain only very few of the mental diseases.

F. Mesmer and the French School

Long before the rise of the German psychiatric school with its predominantly organic orientation, a psychological approach had been attempted by Mesmer, in the latter part of the 18th century. He used hypnosis in a somewhat charlatan-like fashion which actually disguised its scientific contribution. Mesmerism never really disappeared. Gradually, a school of thought came into being which approached mental illness with strictly psychological methods, based chiefly on hypnosis and suggestive therapy. The value of such methods was recognized by Braid and Elliotson, later giving rise to the so-called French school with Liébeault, Bernheim and Charcot as its leading exponents. From these, Freud received his first impressions leading directly to the development of modern concepts of mental illness.

G. The Second Psychiatric Revolution

By 1900, it was clearly established that there were mental diseases with a psychogenic etiology as well as those with a somatic origin. This schism corresponded to the century-old controversy of mind (psyche) versus body (soma). Gradually there developed a consistent theory of mental disease as a response of the total organism to certain experiential stresses, providing some understanding of how psychological factors and emotional experiences result in mental illness. The new era in psychiatry which began at the turn of the 20th century is sometimes referred to as the second psychiatric revolution. The shortcomings of both the psychogenic and the somatogenic approach gradually became quite apparent. Adolf Meyer and his followers, as well as the psychoanalytic school, both abandoned the notion that the meaning of mental illness could be found in an "either-or" approach. Present

day psychiatrists no longer examine either the mind alone, or the body alone, of an individual. Instead, they consider the whole human being. Modern psychiatry is aware of the fact that when the psychological experiences of an individual are studied, or when the unconscious of an individual is explored, only certain facets of the total organism are being selected for study, but the entirety of the organism is never lost sight of. When certain segments of the personality are selected for study in greater detail, it is because their improper functioning has brought about the malfunctioning of the entire human organism. This approach to the meaning of mental illness, known as the organismic point of view, is the currently predominant one. According to its concept, mental illness is an expression of the total human organism. It is to be remembered that the difference between the mentally ill and the mentally healthy, well integrated person is a difference of degree rather than of kind. The so-called normal person is subject to the same inner forces, environmental pressures, and conflicts as are found in mental illness. In the continuum of health and illness there is only a quantitative difference between the two.

II. Causality and Mental Illness

The search for a cause in order to explain a given phenomenon is as old as the ability of human beings to think and to reason. Repeated in each generation, the insatiable curiosity of even very young children has been universally observed. Almost as soon as the child learns to talk, he begins to ask, "Why?" It is, therefore, not surprising that there has always been a search for the cause of mental illness. There are many popular misconceptions about this, some of which are quite misleading and even dangerous, because they are far from the truth. There are, to mention but a few, those who think that overwork, bad company, sexual abstinence, sexual overindulgence, constipation, the

weather, an upset stomach, or poor appetite can cause a mental disease. It is recognized, of course, that these may be symptoms reflecting the presence of a mental disorder, but they are not to be confused with being the cause of the disorder. Actually misconceptions like these reflect primarily a desire to avoid or deny the real problem.

Psychology, psychiatry and related professions, have always looked for the cause of mental disease, and rightly so. But, not until mental illness was approached scientifically, divorced from magic and religious doctrine, was any better understanding or progress possible. Only then could mental diseases, like other diseases, be recognized as having a definite cause, and being neither fortuitous, nor magical, nor demoniacal. For a long time, scientists have searched for a cause, but as yet no single cause for all mental diseases has been found. The many varieties of mental diseases and the complexity of their manifestations, even within one disease make it difficult, if not practically impossible, to see how any one cause could lead to such a multitude of phenomena. It appears more likely that in a given individual, it is a combination of causes, biological, psychological, physical, and social, which lead to an emotional disorder.

A. The Rationalistic Approach

The peak of the rationalistic philosophy, as formulated by Descartes, Voltaire, and Kant, attempted to establish reason as the primary motivating force in human behavior. When applied to mental illness, laws of logic and reason did not contribute any better understanding because they did not take into account the irrational in man, the emotions, which are the core of mental disease. It has been said that the only logical thing about mental diseases is that they are illogical. It is this apparent lack of logic which makes them so difficult to understand in terms of simple cause and effect. Mental diseases are for the greater part emo-

tional difficulties, and emotions have a logic of their own. For this reason, the biological rather than logical approach is more fruitful for the understanding of mental illness.

B. Organic Causes

It was mentioned above that the somatogenic point of view is still widespread. This school of thought maintains that mental illness is due to some abnormality or pathology of the brain. This appears plausible since impulses for thought and action originate in the brain. Furthermore, mental illness for the longest time was believed to be a disturbance of thinking and reasoning rather than of emotions. It is quite true that psychiatry recognizes certain mental diseases which are primarily caused by structural, organic brain damage, and in which this damage is largely, but not entirely, responsible for the mental aberration. It is now generally agreed that the environment and the pre-existing character structure also play an important part. This small category of "organic" mental diseases is comprised chiefly of those associated with infection, especially infection of the brain; those which usually affect older people; those which affect the blood vessels of the brain; and some in which poisons or chemicals play a role. The most widely known of the organic category is paresis, a condition in which the syphilitic infection involves the brain. The history of paresis was a triumph for the somatogenic school, inasmuch as paresis was a known mental disease long before it was demonstrated that it was caused by a syphilitic infection. This discovery probably was a great stimulus to the "organic school," but they were never again able to duplicate this feat. Nevertheless, there is a school of thought which continues to believe that there must be some organic brain pathology which causes most, if not all, mental illnesses. They realize that this pathology has not been demonstrated for the majority of mental illnesses, but they continue to assume its existence and to search for it.

C. Constitutional Factors and Heredity

For the last 80 years, psychiatry has looked for a cause of the large group of so-called functional disorders. Included among the functional disorders are most psychoses such as the various types of schizophrenia, the manic-depressive psychoses, involutional melancholia and paranoia, as well as the psychoneuroses, psychosomatic diseases, and a group which is called behavior and character disorders. A frequently propounded cause for these mental diseases is the constitution of the person. By this is meant the sum total of attributes, both physical and mental, which are inborn, unchangeable and predetermined by the original germ plasm from which a human being develops following fertilization. Constitutional factors are not to be confused with hereditary factors, since only a few of them are hereditary. The majority of mental diseases are not hereditary, although in some of the chronic psychoses hereditary factors repeatedly have been postulated. There are only very few mental diseases which definitely and beyond any doubt have been established to be hereditary. The constitutional school which has many adherents, believes that behavior and mental diseases are based on certain constitutional factors. One cannot deny the existence at least of such constitutional factors, especially certain nonspecific constitutional weaknesses which would predispose to mental disease. However, it is one thing to concede the existence of such factors; quite another to find a practical application for this point of view. Granted that there are constitutional factors in mental illness, by their very nature, nothing can be done about them. Life experiences, on the other hand, can be dealt with therapeutically. Freud pointed out that one first must know fully the earliest environmental experiences of the individual in order to distinguish them from the constitutional factors.⁵

D. Metabolic Factors

Since about 1900 many authorities in psychiatry have believed that mental diseases are caused by certain biochemical changes in the body. Many attempts have been made to demonstrate certain physiological, biochemical, or metabolic alterations in certain mental diseases. This movement parallels the tremendous progress being made during that time in physiology and biochemistry, demonstrating how the search for a cause is influenced by contemporary thinking in related fields. There are also those who seek for a cause of mental disease in the association to be found with endocrine disturbances or certain vitamin deficiencies. There are only a few vitamin deficiency diseases which in rare instances, if far advanced, cause mental illness. However, as a whole, the concept of the biochemical, metabolic, or endocrine etiology of mental illness has not yet been supported with conclusive scientific evidence. Especially, it has not yet been demonstrated conclusively that certain biochemical or endocrine changes are specific for a particular emotional disorder. In the opinion of many, it appears more likely that such changes as have been found are secondary to the emotional disturbance or merely accompany it. Similarly with respect to the endocrine theories, hormones seem to play little or no role, not even in involutional melancholia which affects middle-aged people who have difficulty adjusting themselves to changes in their life situation, particularly to the psychological trauma involved in the loss of their reproductive capacity.

E. Early Psychological Factors and the Unconscious

Current psychiatric concepts put primary emphasis on emotional factors and the psychological effect of certain life experiences as causes of mental illness. Most of the present formulations are based on the observation and theoretical formulations of Sigmund Freud. He contributed an entirely new understanding

and insight into the nature and causes of mental diseases. Perhaps the key to this modern concept is the existence of vast areas in everyone's mind which ordinarily are not accessible to consciousness, and are called the unconscious. There are many observations which support the existence of the unconscious, in which processes take place of which the individual never becomes aware. Somehow, it appears, all the many details of an individual's life experiences are never really forgotten, but instead are stored away in the unconscious, or leave their mark there. Things which happened to an individual in his childhood, or at any time in his life, which may seem to have been forgotten can be brought again into consciousness by psychiatric procedures such as hypnosis. However, life experiences and environmental influences make up only a part of the unconscious. There is an equally important part filled by the individual's fantasy life, things which have never in reality happened to the individual but which he may have hoped or feared would happen.

The concept of the unconscious was known before Freud, but the systematic integration of unconscious processes with mental illness was one of his main contributions. It is now recognized that an individual's conscious emotions and thoughts do not in themselves reveal the cause of an emotional disorder. However, it is often possible to discover the causative factors when the study of a patient includes his unconscious processes, his previously repressed wishes and thoughts. Originally it was thought from studies and observations of hypnosis, that certain traumatic events of adult life which were retained in the unconscious, caused certain emotional disorders. However, it was soon recognized that such events were primarily precipitating factors, and that the disorder invariably went back to traumatic events of infancy or childhood which were found to be well retained in the unconscious. It is understandable that many events and inner

feelings are traumatic for an infant because he is poorly equipped, both physically and emotionally, to cope with the complexities of life. He depends to a much larger degree than the adult upon such basic emotional gratifications as the love of his mother, or the satisfaction of eating, since he has as yet few other sources of gratification. He is, therefore, highly vulnerable when the necessary satisfactions are not forthcoming. Such an experience leaves an imprint on his unconscious.

Infantile experiences and early relationships, because of their actual or potential traumatic significance, therefore assume increased importance in such a theory of normal or abnormal personality development. Mental illness then springs from infantile trauma, usually multiple, which in itself, however, is not enough to account for the occurrence of illness. As is known from many observations, when this infantile trauma has been inadequately resolved and has not, as it were, been quite digested, the addition of traumatic events later in life may precipitate an illness. Such a theory does not overlook the presence of constitutional factors, predisposing to, in a nonspecific way, rather than specifically causing mental illness. The important role parents play in the early development of a child makes it understandable that parental neurotic behavior may be perpetuated in the offspring by sheer imitation. This is often mistaken for heredity. Such behavior is really based on early experiences and might be called "psychogenic heredity."

F. Instincts

It has been found with constant regularity that the causes of mental illness have something to do with so-called infantile sexuality.⁶ This concept refers to the existence of strong sexual urges and instincts which find various expressions, especially in the love relationship within the family, but which are not identical with mature (genital) sexuality although they should be considered

its forerunner and foundation. Among the frequently occurring infantile traumatic events which lead to unconscious conflicts are the extreme concern of the child with his genitals and his attachment to the parent of the opposite sex. However, the existence of unconscious infantile conflicts or fantasies raises further questions. Where do these conflicts and fantasies originate and what are the driving forces behind them? It appears that there is more to the content of the unconscious than a storehouse of earlier experiences and fantasies. It seems likely that certain events are traumatic to a particular individual because they do not meet that individual's innate biological needs. Just as only the man who is hungry will find it unbearable to be without food, so lack of love is traumatic to an infant, because infants have a basic need for love. These inborn needs which form a major part of the unconscious are called instincts or drives. Present psychoanalytic thinking distinguishes two such drives: an erotic-constructive drive, and an aggressive drive. Both of these drives demand satisfaction and are fused in the well balanced individual. The instinct theory is quite complex and difficult to understand, but simply put, the aggressive drive is the more difficult one for the individual to control. The erotic drive in itself seldom gives rise to conflicts and emotional difficulties but the anxiety associated with the aggressive drive is a major cause of emotional disturbances.

G. Cultural Factors

Frequently it is heard that mental illness may be caused by unsatisfactory social conditions such as poverty, inadequate housing, lack of opportunities in life, death of a loved one, or other potentially traumatic environmental situations. There are others who emphasize cultural taboos and restrictions, and the complexity of social conventions as the cause of mental illness. They point particularly to the existence of many taboos and prohibi-

tions with respect to adult sexual urges. Such concepts are too limited. They do not take cognizance of the totality of the personality in all its manifold aspects. Furthermore, many mental diseases appear to be entirely independent of the culture in which they occur. For example, schizophrenia has approximately the same statistical incidence in Switzerland, Great Britain, Japan, and the United States, in spite of the differences in their cultures.⁷ However, the controversy over whether it is environmental trauma and cultural taboo, or aggressive instincts threatening to emerge, which cause mental illness is probably only an apparent controversy. It is thought by many that these environmental factors upset the balance of the instincts and threaten the integrity of the individual with an outburst of aggression. The combination of both elements, the aggressive response to environmental trauma, particularly in infancy, ultimately may give rise to mental illness. Neither factor by itself can be considered causative.

Summary

In conclusion, it can be seen that in emotional disorders one must consider a complexity of causes rather than a simple cause-effect relationship. In response to infantile trauma certain biological drives, with which the individual is born, are altered in their direction, balance, or object investment. The infantile trauma is the primary causative factor which later is reactivated in adult life, principally by events which become traumatic because of their similarity to the earlier infantile trauma which has left its mark. Often in mental illness the repetition of the infantile conflictual situation can be observed. Individuals may also become susceptible to mental illness when several traumatic events coincide, the vulnerability of the individual to this combination being determined by his previous life experiences. All of this, of course, takes place in the unconscious so that the individual himself has no awareness of why he is reacting as he does.

It is thus that constitution, instincts, psychological and environmental or cultural forces all are interwoven in a complex pattern to cause mental illness.

III. The Meaning of Mental Diseases

A. The Significance of Symptoms

While mental diseases are fundamentally not different from other diseases except in their multiplicity of causation, there is a difference with respect to the importance of the cause. In medicine, in general, the cause is all-important in that it provides the key to the illness.

In mental illness, however, in order to understand the basic emotional disturbance, it is necessary first to determine the meaning of the symptoms. Consequently it is not of such immediate concern to the psychiatrist to know what is causing certain mental symptoms. One might almost say the cause is of secondary importance as compared to the meaning of the symptoms.⁸ It can even be said that progress in the development of psychiatry was delayed so long as psychiatrists persisted in looking for a cause while overlooking entirely the symbolic meaning of the presenting symptoms. For too many years, little attention was paid to the significance of the behavior or thoughts of neurotic or psychotic patients. In fact, these were often considered absurd and irrelevant, having no meaning whatsoever, and were even sometimes ridiculed or made the subject of jokes. This was especially the case with psychotic manifestations whose symbolic meaning was most difficult to understand, and whose significance was missed. For example, for many years the preoccupation of many psychotic patients with sexual problems had been known, but no particular meaning was attached to this other than obscenity. The occurrence of such thoughts in such a large number of patients cannot lightly be dismissed as a coincidence. Lack of understand-

ing of the symbolic meaning of a patient's symptoms has been partly responsible for the inhuman treatment which has been given the mentally ill for so many years. One of the greatest contributions of modern dynamic psychiatry is the recognition it has given to the fact that symptoms have a very specific meaning, even though it may often be very difficult or perhaps impossible to determine precisely what that meaning may be. Actually, it is only since more attention has been paid to the meaning of symptoms that more has been learned about psychological causative factors. Of equal importance, is the fact that better understanding of the meaning of mental illness has provided better therapeutic tools. Such a concept which ascribes a specific meaning to symptoms, implies that they are not accidental or senseless, but that they are predetermined and there is a definite psychological reason why each of them occurs as it does.

B. Defense Mechanisms

Mental illness might be defined, in terms of present dynamic understanding, as the reaction of the total organism to external or internal stimuli which seriously alter the equilibrium of the individual.⁹ This equilibrium is often referred to as homeostasis. The word "seriously" in the above definition may need some amplification, insofar as it refers not only to objectively serious stimuli but also to those which are only subjectively felt as seriously upsetting the emotional balance. This definition implies that unconsciously an effort is made by the individual to reestablish a certain equilibrium, and this in turn implies the existence of compensatory dynamic forces in the human organism which can accomplish this. The chief purpose of these forces is to provide a protective mechanism. Protection may be needed to prevent severe psychic pain that would otherwise result from unconscious anxiety; or to prevent the threatened emergence of

aggression which is unacceptable; or even to prevent total psychological disintegration. The function of these psychological defense mechanisms, therefore, is to reestablish homeostasis. Many examples could be drawn from the everyday life of normally functioning individuals to demonstrate how such defense mechanisms work.

C. Rationalization, Projection, Displacement, Identification and Repression

A very common defense mechanism is known as *rationalization*. This refers to an unconscious method of plausibly explaining, justifying, or accounting for certain feelings, ideas, or behavior. The explanation arrived at invariably appears to be the result of logical thinking, but conceals the real underlying emotional determinants. Justifications for recurring failure in life, or explanations for excessive drinking are usually rationalizations. The well known fable of the fox and the sour grapes is a good example. The fox who really wants the grapes, but cannot reach them, justifies himself to the other animals by saying that the grapes are too sour. Another such defense mechanism consists of unconsciously ascribing to another person those thoughts and impulses which actually arise in oneself but are inadmissible. This is referred to as *projection* and finds expression in such things as feelings of suspicion, in blaming others for one's own mistakes, or in blaming the teacher in school for one's own poor progress. *Displacement* is another defense mechanism. Feelings and emotional values attached to one idea or person are transferred to another object. The display of excessive emotion over a trivial event is a manifestation of displacement. For example, an employee has been severely criticized by his supervisor but given no opportunity to express his resentment. Subsequently, in a different setting, some trivial event such as being served a cup of coffee not quite hot enough sets off an outburst of anger. The

person is not aware that the original emotion has only been displaced onto another object. Another defense mechanism is *identification*, a device by which an individual unknowingly acquires attributes of another person who represents for him an ideal or model. The most basic of all defense mechanisms is *repression*. This refers to an entirely unconscious process by which unacceptable primitive urges or wishes are turned back when they threaten to enter consciousness. Repression is the first step in any defense reaction, followed secondarily by any of the other protective devices. In the illustration given above, the hate felt toward the supervisor is first held back, before it is displaced onto another object. Similarly the fox's desire for the grapes is first repressed before it is rationalized away by saying they are too sour. These are but a few of the defense mechanisms utilized in everyday life.

D. Mental Disease as Defense Mechanism

Mental illness itself is basically a defense mechanism, unconsciously erected as a protection against anxiety or an unbearable emotion. There is this difference, however. In the well person, the defense mechanism fulfills a useful purpose by reestablishing the emotional balance. In mental illness, the defense mechanism is so exaggerated and disproportionate that it consumes an increasing amount of energy, until there is little if any energy left with which the individual can engage in useful activities or cope with everyday life. When that happens, the totality of these defenses constitute the mental disease, and the patient is said to have symptoms, which however form only the outward manifestation of the illness. It is as if his defenses were working overtime against unbearable anxiety. These defenses have a meaning, serve a definite purpose and have a definite economy. While they may cause discomfort, they may prevent a more painful situation, as would be the case if the underlying anxiety or uncon-

scious drive were permitted to become conscious. The mere description of symptoms, without determining their meaning, offers little toward the understanding of mental disease. Appearance of symptoms is only the outward sign of the disease process, just as fever is not a disease in itself but signifies the presence of an underlying infection.

E. Conversion Hysteria

The following case of *Conversion Hysteria* demonstrates clearly the meaning of mental illness as a defense mechanism. A young lady consulted a physician because of loss of feeling in her right thigh. No organic or physical cause could be found to account for the condition, and the innervation of the skin area was intact. The patient related that the condition had come on shortly after the death of her father whom she had loved and cared for during his illness. Under hypnosis, she related the following data of which she was not consciously aware. She had fallen in love with the young physician who attended her father during his last illness, and felt guilty that she should have had such desires while her father lay dying. One day her thigh had brushed against the doctor's leg as he bent over her father's bed. The sexual thrill that she felt at this contact enhanced her conflict and guilt feelings to the point that she developed the loss of feeling in her thigh following her father's death.¹⁰

The mechanism of this illness is quite apparent. The shock of her father's death was the precipitating factor which activated guilt feelings about having loved the physician when she should, as she thought, have devoted all of her attention to her father. That such guilt feelings accompanied her falling in love, points to a feeling of anxiety which probably was aroused in her earlier years when such feelings of love, very likely in relationship to her father, had to be shared with her mother. Because the anxiety was too painful, it was repressed. The meaning of her loss of

feeling in her thigh is fairly clear, since it abolished all sensation from the area in which the forbidden impulses originated. At the same time the forbidden sexual wishes which she had for the doctor were also repressed. This is often referred to as the primary gain of an illness, or the resolution of the conflict. There is another meaning in this illness. The absence of feeling in her thigh could have prevented the sexual thrill in the first place and would do so in the future. It represented a denial of the actually desired situation. There is also a secondary gain in this illness, insofar as it allowed her to claim attention from the same or another physician.

F. Phobia

Reversal in terms of symptoms, meaning that the real underlying desires are exactly the opposite of the presenting symptoms, is a fairly common defense mechanism. The "old maid's neurosis," characterized by a fear of being seduced, actually means that unconsciously there is a wish to be seduced. This wish is too dangerous, so strong barriers are unconsciously erected against it. Reversal of feelings takes place so easily because of the close proximity of opposites, like love and hate, in the unconscious. The meaning of phobias is illustrated in one of Freud's early cases, that of Little Hans who suffered from fear of horses.¹¹ Treatment revealed that Hans actually feared his father but had displaced his fears onto the horses which his father rode. Once this was understood, the seemingly senseless symptom acquired a definite meaning. The most common phobia is a child's fear of darkness. Such fears in adults usually refer to unresolved fears which arose during childhood.

G. Compulsion Neurosis

A morbid need for cleanliness, such as spending most of the day washing one's hands or face, or being unable to stop the

cleansing process after going to the toilet, is considered a compulsion neurosis. Such excessive need for cleanliness has symbolic meaning. It may provide gratification for desires which previously were ungratified. A patient will sometimes spend hours on the toilet and then take more hours to clean himself, or require another person to clean him. The meaning of these symptoms is that the patient is seeking certain gratifications which were appropriate for a small child during bowel training, but not for an adult. The compulsion of constant washing usually refers symbolically to a need to "wash off" some guilt feeling and to atone for some forbidden desire. In either form of compulsion neurosis, it is necessary to understand the hidden meaning of the act, which on the surface may appear quite childish or senseless.

H. Other Examples

Depression is a mental disease, in which the patient suffers a loss of all interests, often with inability to eat, and generalized slowing down of responses. This represents a defense against an overwhelming unconscious aggressive impulse. The generalized retardation in depression is a particularly strong protection against any possible aggressive outburst. Feelings of guilt for having such wishes also enter into the picture and account for the self-destructive tendency.¹² Difficult as it may be to understand, the possibility of suicide may appear to the depressed patient to be a less painful alternative than to continue to live with his intolerable aggressive impulses.

In the group of mental diseases known as schizophrenic reaction, the symbolic meaning is particularly difficult to recognize. The psychotic manifestations of these patients are extremely bizarre. The withdrawal from reality into a world of their own seems to be the only way for them to avoid complete psychological disintegration and chaos. The life of fantasy is apparently more

bearable for the schizophrenic than the complexity of social interaction. There is reason to believe, though it is by no means definitely established, that this withdrawal from reality is sometimes a protective device against a painful feeling of being rejected. The total behavior in this illness appears to be that of a person who has regressed to his childhood, usually to the earliest phases of infancy. Many of the thoughts and feelings which are expressed would be appropriate for an infant or small child, but not so for an adult, and consequently bring the patient into conflict with reality. The patient's delusions and hallucinations are an effort toward restitution, an attempt to re-establish some relationship, not with reality itself but with some more bearable, self-constructed, pseudo-reality. There are many other ways in which schizophrenics attempt to regain the equilibrium of their disturbed emotions, manifested in a variety of apparently bizarre thoughts and behavior. Their meaning is chiefly determined by the personality organization of the particular patient and by his early life experiences.

These are just a few examples to illustrate the meaning of mental diseases. Beyond the general meaning of the symptoms in the various diagnostic categories, each symptom in a given individual has a specific meaning. The concept of the meaning of mental diseases and their manifestations implies that they are not the product of chance but are strongly determined by previous life experiences and biological forces.

IV. Summary

The modern psychiatric approach to mental illness considers the human being in its entirety. In this organismic approach psychological factors are especially emphasized as well as somatic factors, each being considered merely a different facet of the total personality.

Mental diseases have multiple causes. There are a few in

which organic, structural pathology plays an important part. However, in most mental diseases no such pathology has been demonstrated. Modern trends in psychiatry emphasize emotional factors and the psychological effect of life experiences in the causation of mental diseases. Primary importance is attached to unconscious, rather than conscious, processes. In addition to these, constitutional, biological, social and cultural factors play a part. The combination of these forces under certain conditions causes mental disease. Schematically, this might be expressed as: Constitution + Instinct, + Infantile Trauma, + Precipitating Events = Mental Disease.

The symptoms and manifestations of mental diseases have a definite and specific meaning. As a whole, they are considered to be a psychological defense mechanism which attempts to re-establish equilibrium within the personality. Disturbance of this equilibrium may have been brought about by overwhelming anxiety or by the threatened emergence of aggression in response to environmental stress. In contrast to normal defense mechanisms, mental illness consumes a large portion of the individual's available energy thereby becoming vicious and uneconomical, leaving insufficient energy to pursue other goals in life. The particular meaning of each symptom in a given individual is determined by his unconscious processes and previous life experiences.

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Chapter IV

MALADJUSTMENT

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By

WILLIAM H. MIKESELL, Ph.D., Psychologist
Municipal University of Washburn, Topeka, Kans.

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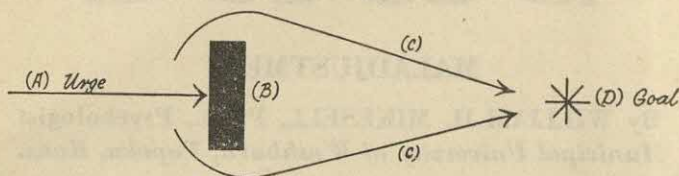
By WILLIAM H. MIKESELL, Ph.D., Psychologist
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Introduction

The meaning of frustration is confusing to the student who first studies the problem. The varied definitions baffle him. Symonds¹ says that frustration is only a barrier, whether one gets around it with learned or unlearned responses. Woodworth and Marquis² say that it is defined in two ways: according to the barrier making for the frustrating, and, in the second place, according to the response to the barrier. Young³ says there is frustration when there is pronounced irritability, unhappiness and moroseness. Maslow and Mittelmann⁴ say that frustration is that which lowers the general esteem of a person. Zander⁵ says that frustration is not frustration unless the thwarted urge is something attainable. Here we see that frustration is defined in at least three general ways: (1) as just a barrier whether one gets around it or not, (2) as a reaction to the barrier, and (3) as merely certain aspects of frustration, as seen in the definition of Young and Zander.

We, in this present chapter, shall define maladjustment as a certain kind of reaction to a barrier. Maladjustment is a thwarting of a personality because an urge cannot be satisfied in the direct, but may or may not be somewhat satisfied in an indirect manner. This may be illustrated by the following diagram where,

A, represents a blocked urge, B, the barrier preventing direct approach to the goal, and C, a round-about-way, which we shall call "indirect" to reach the goal, represented by D.



The above diagram representing frustration also represents maladjustment. These two in this sense we are making synonymous. Note that maladjustment is a complex situation and as such is difficult to define in a few words. But in a general way we may say that a person is maladjusted when he is more or less permanently cut off from the natural or direct way of realizing an urge and is either completely blocked within himself or gets some relief from an indirect manner of living. If there is no inward relief, a breakdown occurs. If there is some relief, then the person is able to function wherever he is.

The direct way of granting fulfillment of an urge is the natural or straight-forward manner. The indirect is obviously obtaining some sort of fulfillment in a way other than the natural manner. For instance, we naturally seek romance or love from human beings. But if a woman has been deprived of love in childhood and finds her desire still frustrated in adulthood, she may seek and get it through a pet dog in her home. If a man has not been able to get along with people and feels, thereby, a sense of failure, he may seek a peculiar hobby in which to find a mastery, though hobbies may serve other than the indirect way of living. The mechanisms or patterns of behavior employed in indirect living are called defense mechanisms, set up as a defense to cover up frustration and also as a defense against further humiliation—and are face-saving devices. The two big

general classes of defense mechanisms, the withdrawal and aggressive, will be discussed in the following two chapters. We desire to employ the present chapter in presenting only the cardinal points of the human situation called frustration or maladjustment.

We shall divide the chapter into two general discussion sections: one to be devoted to the question, "What *IS* maladjustment," and the second to the question, "*WHAT* is frustrated?"

I. What is Maladjustment?

In choosing from a number of ways of describing maladjustment, our choice of the present method is to furnish the student, taking his first course in abnormal psychology, with a simple and definite explanation of this very important problem. There will be no attempt to be comprehensive or to discuss all aspects of maladjustment. This would be preeminent, and the space of one chapter would not allow it. But the chapter aims to provide at least a fairly good working knowledge to the student of the subject. In providing some critiques of maladjustment, we shall present six aspects in this first section: (A) the meaning of conflict, (B) postural tension, (C) the sense of inferiority, (D) the description of the principal symptoms of the maladjustment, (E) maladjustment as a deviation from the statistical norm, and (F) maladjustment as a deviation from the psychological norm.

A. The Concept of Conflict

No one can grasp the meaning of frustration or maladjustment without also grasping the meaning of conflict. This is a common word employed today by both psychologists and psychiatrists in discussing frustration. Lewin⁶ has provided an often-quoted description of human conflict, though he often employs the term to denote only a temporary set-back. We mean conflict as referring to a permanent set-back. Lewin uses geometry to diagram what

he calls the topology of conflict. When a goal has an attractive aspect, he calls this a "positive valence." When it has a repellent aspect, he calls this a "negative valence." The intensities and directions of the pressures playing upon the individual he calls "vectors." While we have known before his proposed three kinds of conflict, he has given them a graphic and scientific description. The three types are as follows: (1) that in which a person is confronted with two things he wants which are opposed to each other, (2) that in which a person is confronted with a want but there is a repellent to the want, and (3) that in which a person is confronted with two things, neither one of which he wants, and from which he tries to escape.

Why is conflict perhaps the first critique of frustration? Because it is conflict by which the individual is torn within, producing the strains and stresses that demand their toll of mental peace and satisfaction. Within the very heart of conflict there is tension and friction, and it is this which wears down the human being. To explain conflict we may resort to the principle of energy in physics. Energy to be effective should be harnessed and released in a smooth and uninterrupted manner. If a locomotive were to expend its steam in a contradictory manner by attempting to go forward and at the same time attempting to go backward, there is a question of how long this powerful mechanism would be in good order. Conflict in its very nature involves energy going in contrary directions. The nervous system is "pulled asunder." Energy at the same time is going here and going there, at "cross purposes" with itself. We see this principle demonstrated in the following diagrams of the three principal kinds of conflicts, and also in our examples which we shall give from time to time.

Diagram (A) shows the first kind of conflict, in which two wants of an individual are in dead opposition, with the friction point (F) demonstrated by the two arrows coming against each other.

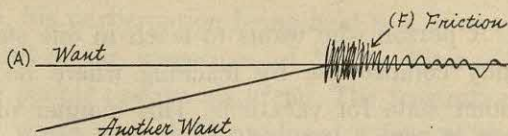


Diagram A

Diagram (B) shows the second kind of conflict, in which a want is pulling one way while a force of fear or punishment, or some negative force, is pulling the other way, demonstrated by one arrow pointing one way with another pointing the opposite, with (F) showing the friction point.

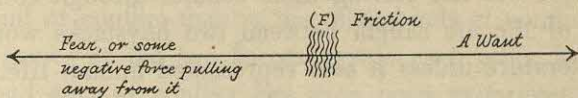


Diagram B

Diagram (C) shows a third kind of conflict, in which the individual is forced toward an object he does not desire. The one arrow shows a withdrawal from the undesired situation while the slanting arrow indicates a force driving the person toward the undesired situation, with (F) indicating the friction point.

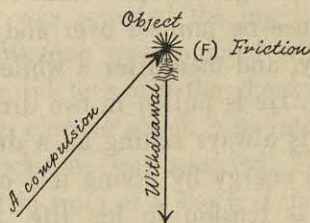


Diagram C

We can readily see in all three kinds of conflict that two contradictory energy-charged forces clash with friction and tension resulting. Let us illustrate these three kinds.

Examples are numerous of the first sort of conflict. Many people are torn between two drives, both of which they want. It is the old story of wanting to eat the cake and have it too. Often people work out a sort of compromise whereby they partake a

little of both. A person who wants to teach in one state and live in another may compromise by teaching where he wants and visiting the other state for vacations. This manner of resolution of conflict is easily adopted by children. A boy wants to stay up an hour later than usual, but he knows that this will displease his mother. He wants to stay up and yet he does not want to displease her. So he compromises by cleaning up the basement and thus pleases his mother and also himself, being rewarded by staying up an hour later. Compromises are often possible, but some people are not solving their conflict through compromise. The tale of the ass caught between two haystacks would never live in literature unless it also represented human life. It is not difficult to find instances of people who stand between two haystacks, as it were, and do not know what to do. Here is the case of a man who apparently in all his life has never yet resolved his conflict. He wants to be in the ministry, but he also wants to continue teaching school. He has been continually wanting at the same time two things which he does not gratify at the same time. He is constantly looking over the other side of the fence at greener pastures. Once he jumped over and partook of the new pasture, the ministry, and then after a while jumped back. Then he was sorry he did. He is pulled in two directions every day of his life. Indecision is always setting up a drag on his mind. He does not resolve his energy by giving it a one-way-run. It is no wonder that there is tension in his life, he being unable to straighten out his urges. He consequently uses up much of his reserve force, and it is a question whether he could weather a really serious crisis. He has kept going despite his maladjustment, but at a cost to his health.

The second kind of a conflict is seen in the person whose feeling of inferiority sets up plenty of friction. He wants to be like other people and partake in various activities but his fear of making a bad showing prevents him from intermingling much

with people, his participation being held to a bare minimum only to assure him of the necessities of living. After all he must associate with people to earn his bread. The frustration of his sense of personal worth as a child produced a fear of the world. This fear produces further frustration by making him pull away from his urge to make friends, from seeking the job suitable to his talents, and perhaps even from marrying the sort of woman he should marry. A sense of inferiority is thus a result of frustration but it can also be a cause and further impede a person. Sears and Hovland⁷ say that there is five times more blocking in this second kind of conflict than in the other kinds of conflict and the intensity grows as the two forces equate each other in strength. This second sort of conflict has even been experimentally produced in animals. Curtis⁸ experimented with pigs by conditioning a pig to lift the lid of a box and get an apple when a 600-cycle tone was sounded, and conditioned it to withdraw its foot when a 750-cycle tone was sounded and accompanied by electric shock. He alternated these two conditionings and repeated them many times until each kind was firmly established. When the 600 tone was sounded the pig lifted the lid for the apple. When the 750 tone was sounded with its shock the pig took its foot off the lid to avoid the shock. But then a mix-up was introduced. The electric shock was introduced whether the food-tone or the shock-tone was sounded. The animal appeared willing to lift the lid in spite of a shock if the apple was dropped in the box, but the experimenter refused to drop the apple in the box until the pig had put its foot on the lid. The pig wanted the apple but it did not want to put his foot on the lid to be shocked. Here was marked conflict. He wanted food, but there was a punishment straining him. The pig showed the conflict by a marked tendency to lift the lid as if to get the apple and also at the *same time* to raise its foot as if to avoid the shock. Here was marked confusion. The pig finally became "sulky" and showed other abnormal reactions.

Maier⁹ experimented with rats to produce conflict. He trained a rat to jump against a card with a black circle on a white background, and knock it over and enter a box and get its food. Then he trained the rat to avoid jumping against a card with a white circle on a black background because it could not be knocked over and the rat fell into a net as its punishment for an incorrect response. Then the experimenter switched the cards. A jump to the white circle might be rewarded by food and a jump to the black circle might bring on punishment. Then whether the black or the white circle card was placed before the rat it was forced to jump by a blast of air against it. Here was quite a mix-up. If he jumped to the white circle and got food he was punished by the blast of air. If he jumped to the black circle he might receive two punishments: falling into the net and being given the blast of air. Thus the rat had two situations of Lewin's second kind of conflict. It wanted to jump to the black circle for food but punishment was pulling him away from it. It finally wanted to jump against the white circle towards the end because this sometimes was rewarded by food but an urge fought against it also because of punishment. It did and did not want to jump. What was the effect of this sort of conflict? Many of the rats showed extremely abnormal behavior. Some leaped from the platform to the floor, ran around in circles so fast that even the movie camera could not follow them. Some rolled over in convulsions of epilepsy. Some hopped along like rabbits, showed very sudden jerky movements and rolled into immobile balls. Some remained as immobile balls for as long as eight minutes. An interesting result of the experiment was that the rats soon recovered, but the abnormal behavior could be repeated by repeating the conflict. These animal experiments show that conflict lies at the very heart of maladjustment and produces disorganized behavior.

The third kind of conflict is frequent. Here we have the situa-

tion where one does not want to do a thing but if he does not, then there results bad consequences or punishment. A boy of an aristocratic and snobbish family is asked to play with a boy of the neighborhood of the same kind of family, whom he dislikes. He does not like the scolding and punishment he will get at home if he does not play with him. Since he hates the punishment worse than he dislikes the boy, he is forced to play with the boy against his will. If this is a temporary situation, nothing serious will come of it. But if the same sort of thing continues throughout his childhood, and he is forced to do many disliked things to get away from punishment at home, he will naturally generate constant tension, which will seriously affect his entire life. Sometimes such a child is under compulsion to enter a certain vocation of the parent's choice but not of the child's. He may even be pressured to marry a girl whom he does not love because of her social and financial standing. Such parental threat may easily result in neurotic children. We can readily see that when we are forced to go in a direction that runs contrary to our desired direction, the vectors are at cross-purposes and easily damage the integration of the mind.

It is not difficult to see the neurotic and pathological implications in the conflict-situation. If the strain of inward conflict becomes too much there is developed either neurosis or psychosis, which will be explained elsewhere in the volume. Sanitariums and mental hospitals are filled with patients whose friction between opposing drives became unbearable. Let a machine generate too much friction between the cogs and it will not be long until the strain may render the machine ineffectual or useless. So with the wear of tension on the human nerves. A common example in which strain reached the breaking point was that of the soldier of the late war, torn between patriotism and personal urge for safety. Such men had a terrific fear in battle but at the same time they strongly wanted to do their duty. Here

was a "tug of war" going on within them. Just as a "tug of war" game may eventually snap the rope in two, so this terrific tug of nerves of many a soldier finally rendered him unfit for further duty and found him in an army hospital.

Freud made a great deal of the second type of conflict. He shows that a woman may unconsciously want something which to her is repellent. A woman made prudish in childhood by her mother's instilling in her a disgust for sex would have this sort of conflict. She wants marriage and yet she does not want it. She wants love and yet she does not want it. But she may be unaware of the nature of her conflict. All she knows is that she is a "nervous wreck" and comes to the psychiatrist or psychologist for help. She repressed her love of men, and her conscious mind keeps it repressed. But her unconscious mind wants romance. Her conscious mind is pulling her away from the thing she unconsciously wants. Hendrick¹⁰ also locates much of conflict in the unconscious. He even claims that an unconscious wish may be repressed because of an unconscious anticipated self-punishment coming from the so-called *superego*, which is merely another name for conscience. Much of the system of Freud is taken up with the conflict between the Id, the unruly unconscious with its inherited vicious and barbarous drives, the Ego, which is the self as we generally live it representing our adaptation to society, and the Superego which, as we said, represents our ideal of living and as such may be very severe not only in criticizing the Id but also the Ego. There is objection to Freud in making too much of the Id. But this is natural, for since Freud was the first to clarify the concept of the unconscious he and his followers, such as Hendrick, would easily overemphasize the unconscious. There is little evidence for the Id and there is not as much evidence for a conflict between the unconscious and the conscious as their exponents suppose. Many of their alleged unconscious conflicts are really conscious, and it does not take much analysis to show

that such is the case. Many a woman knows that her conflict is an open battle. She openly knows that she does and does not want a marriage and when this battle becomes intense her nerves may pay a big bill.

The third type of conflict may also display neurosis. A puritanical wife, driven too much by the stern whip of duty, may thus be forced to stick by a husband who has cruelly mistreated her. A neurosis may become a psychosis if the conflict-situation in the nervous system produces a mental derangement severe enough to render a person unable to carry on his normal occupation. But psychoses may be complicated by organic pathological conditions.

B. Postural Tension

Another important critique of frustration, or maladjustment, is that of postural tension. Maladjusted persons are said to be "tight" inside of themselves and do not know how to relax. This tension is always a concomitant of frustration and grows out of the conflict-situation. Naturally such a person is constantly upset and is in a more or less constant state of emotion. The divided and strained nervous system, growing directly out of conflict, sets the internal stage for emotion. Cannon¹¹, the noted physiologist of Harvard, describes this sort of division. He shows that the automatic nervous system, serving our vital internal processes, has three divisions, one of which may be antagonistic to the others. The cranial and sacral divisions, called the parasympathetic, keep in good running form the digestive, cardiac, and other vital organs. The third division, called the sympathetic, also functions in controlling our vital internal organs. But with this big difference! When it comes to a crisis, or a supposed one, the internal organs are thrown into an intense activity to prepare the organism or individual to meet the crisis, by providing him more strength to meet it. It is the sympathetic nervous system

which is set into heightened operation accelerating and inhibiting certain vital organs during a crisis. For instance, the cranial system keeps the heart in normal running order. In an emotion, the heart is accelerated. The cranial sends impulses that provide a normal functioning of the stomach. In an emotion, the sympathetic upsets it and drains from it blood and energy and cuts down the digestive juices. The sacral helps keep our bladder in normal working order. In an emotion the bladder is disturbed. But this upset of the nervous system is necessary to rush reinforcements to the part of the body needing more strength.

The sympathetic nervous system, in an emotion, is constantly at war with the cranial and the sacral. With the maladjusted person, there is always so much tenseness and tightness that one is constantly acting *AS IF* there were a crisis on hand. Jost¹² has shown that in frustration there are actually physiological changes in the sympathetic nervous system that are present when one is disturbed by an emotion. Since frustration produces such a physiological change, what sort of an emotion is most prominent in the maladjusted individual? It is that of anxiety, which is a dread of impending danger. It is present in all sorts of degrees, but whether little or pronounced it is a constant fear, not of what HAS happened but what MIGHT happen. It is a state of dread, the very heart of the emotion of anxiety. The maladjusted person is constantly uneasy about tomorrow, and is constantly upset physiologically, being in a state of readiness to jump away from the world. Thus the maladjusted person is often unhealthy because much of his needed energy is drained away by his strength-sapping emotional state of anxiety. The rigidity as seen in anxiety appears to indicate that the person is holding back his energy. This is true, but anxiety nevertheless tremendously saps energy in contrast to the energy conservation of relaxation. Anxiety as the emotion of dread for the future is perhaps the greatest thief of our energy. Its special behavior pattern of

rigidity shows this. When persons reach the psychoneurotic or psychotic stage, anxiety shows tenseness written even on every single feature of his face.

C. The Sense of Inferiority

Another intrinsic and very prominent characteristic of maladjustment is a sense of inferiority. But we must be careful and recognize the special brand inherent in maladjustment. Today we hear people announce even very glibly that they have an inferiority complex, but they do not realize what they are saying. This phrase is an ominous one and should not be used lightly for any and every kind of a lack of confidence. People who feel a lack of confidence in this or that endeavor may not have a serious handicap and are very far from being maladjusted.

What most people have in mind when they say that they have an inferiority complex is that they have a fear of engaging in this or that isolated endeavor. The writer knows of a Bishop of the Methodist Church who confessed to the writer that he was afraid of speaking to small groups although he got a thrill out of addressing an audience of two or three thousand people, and wondered whether he had an inferiority complex. Observation of the man would soon reveal that he was far from possessing an inferiority complex—just the opposite—. Somehow or other this man had developed a timidity of speaking before a small group but it is not serious. It does not bother him very much and as far as the total number of activities are concerned in which he takes part it is insignificant. True, there is a frustration of the basic urge of achievement, but this sort of frustration does not affect much of his personality. Many a business man has said to the writer that, "I couldn't make a speech to save my life. If I had to do it, I would fall through the floor. Audiences scare me to death." Does such a man have an inferiority complex? Far from it. This timidity about making a speech does not permeate

much of his life. His total program of living is very little affected. He does not like this drawback and wishes that he might be different, but it is minor item in his personality make-up. Another friend says that he is embarrassed to talk to women at a social gathering, and said, "I must have an inferiority complex that you psychologists talk about." Again let us say that he is far from being afflicted with the dread of a real inferiority complex, because it does not worry him very much and is comparatively insignificant in the total make-up of his personality.

One can even produce a sense of inferiority in the laboratory. If I take some students and ask them to reach for a pencil and then interrupt by holding the arm back when it is extended and prevent their reaching it, I get pretty much of a frustrating situation. The urge for activity when once started has been blocked, also the urge for achievement resulting in feeling, "quite cheap," or "taken back" or a "sense of defeat," as they expressed it, but this sort of inferiority is not serious.

The above illustrations are what we might call, "one-urge-inferiority," because only a segment, as it were, of their personality has been made to feel inferior. But in the sort of inferiority we find in maladjustment we face a very different situation. When I am stopped or thwarted by someone from going to the door of my office or from delivering an address because of rain, the embarrassment or sense of defeat is merely a one-urge-defeat. It by no means spreads to my *ENTIRE* personality. I do not like the interruption and it pricks my pride, but I still carry my head high. Only a *slice* of my pride has been taken from me and only for a short time even as little as a minute or two. But when I am maladjusted my inferiority is a very serious matter. The sense of defeat does not focus itself merely on one urge but on my entire being. The sense of defeat spreads throughout my entire mind. It leaves its mark on just about *EVERYTHING* I do. Even when I go trout fishing I may

show my lack of confidence. It shows in my work, in the way I conduct myself at a party, in the way I play, in the manner of my discussion and even in the manner I made love in my first romance. It is hard to be a Lochinvar. All aspects of my being have been cheapened. My frustration is a stinging blow that floors me for a K.O. in the prize-ring of human battle. This is a real inferiority complex.

Now this general seeping of the feeling of inferiority throughout my entire personality may be on account of just a one-urge frustration. The boy who failed to excell or achieve, on account of illness or a bodily handicap, may have only this one-urge defeat. His other urges may not have been blocked, such as companionship, love, romance, etc., but he nevertheless acts *as if* he has been actually defeated in *EVERYTHING* he does. He holds back in *all* of his activities. He feels defeated throughout his whole being. While he has had a one-urge frustration he has more than a one-urge inferiority. He has a total personality inferiority.

We, therefore, can see that we must make a distinction between a frustration of just one-urge which leaves only a one-urge inferiority and a frustration which affects the entire make-up of an individual. Many, many people are frustrated in respect to this or that urge but not nearly as many are frustrated with its resultant one-urge inferiority in their entire minds, even though actually thwarted in only one urge. Very few people are unfrustrated. We thus must make the distinction between frustration that disturbs the entire mind, which is then maladjustment, and the frustration that disturbs only one-urge, which then is not maladjustment. The very meaning of maladjustment is that the whole personality of an individual does not fit into the various demands of the groups about him, which is certainly not the case of one who is thwarted in only one-urge or so.

Because maladjustment is a critical blow to the sense of personal worth and rocks the entire personality, it is difficult to see

that frustration indicates a mere barrier whether one gets around it or not. Many people have barriers thrust before them, but they mount them and then there is no frustration. Frustration, to our mind, should, therefore, be defined in terms of one's *reaction* to the barrier. When this is a feeling of being blocked in respect to one's whole being, we are witnessing serious frustration and personality damage. When it is only a segmented damage then it is only frustration and not maladjustment. One can easily see that a barrier just in and of itself would not indicate frustration or maladjustment. It naturally depends on our reaction to it which might be excellent, fair or tragic. When Dollard¹³ and his co-authors, in his noteworthy book, *Frustration and Aggression*, says that a mosquito is a frustration, though slight, he deprives frustration of its essential meaning. If anything and everything in the way of an interference causes a frustration then its meaning is spread so thin that it loses its significance. When we know that the entire personality may be disturbed in real frustration then we should confine the meaning of frustration to the *reaction* of an individual for a barrier. Certainly a mosquito would not ordinarily frustrate an individual, even in a one-urge inferiority let alone in a total personality inferiority.

D. Symptoms of Maladjustment

Symptoms are just surface phenomena and do not indicate the cause, but it is well to give a set of symptoms in order to furnish the student a few typical ones of maladjustment. The list is not complete and merely includes the principal symptoms and sums up what we have already discussed.

IN CONTRAST TO

1. A permanently stirred-up inner condition of body, or being constantly held in an emotional state.
2. Concomitant with the emotional state is a characteristic tenseness of living.
3. A proneness to brood over the past and to reconstruct past mistakes with rationalization.
4. Meaningless or too many random motor responses denoting a constant restlessness.
5. A confused state of mind resulting in too much doubt about things but particularly about himself, together with marked indecision.
6. A certain constant sleeplessness, with a sound night of sleep, a rarity.
7. A certain tendency to troubled dreams, the analysis of which probably indicates frustration.
8. A low fatigability, his fatigue being out of proportion to his work, or to the time spent on it.
1. The settled and quiet condition of the average adjusted man.
2. The fairly and constantly relaxed condition of the above type.
3. The adjusted person who has a proneness to think more of the present and future.
4. One who is rather precise and definite in his movements.
5. One who is pretty definite in his thinking and decisive in what he wants.
6. One who is pretty much of a sound sleeper.
7. One who is rather free from troubled dreams.
8. One whose fatigue is always pretty well commensurate with the work and the time spent on it.

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|---|---|
| 9. Often a reduction of sex feeling. | 9. One whose sex feeling is kept normally strong. |
| 10. A total-personality feeling of inferiority with its various qualities, one being that of seeking, even though in a subtle way, unusual attention. | 10. One who has no total-personality feeling of inferiority, but only an occasional one-urge inferiority. |
| 11. Often a too pronounced focussing of energy on a certain activity. | 11. One who spreads his energies over many activities whether he is dynamic or phlegmatic. |
| 12. A pronounced unhappiness. | 12. One who does not raise very much the question of his happiness. |

E. Deviation from the Statistical Norm

Another criterion of maladjustment is the departure from the life of the average man. We do not desire to enter into a prolonged discussion of this critique, for our first chapter treats of the normal and the abnormal rather extensively, but to offer a few lines to afford the first reader in this field another help in understanding maladjustment. When we speak of the average man, we do not intend to convey the impression that the average man is free from all personality difficulties and problems. Everybody has his fighting task of getting along with his environment and of trying to get the most out of life. He has his many mental uprisings and downittings, but as compared with the maladjusted individual he does function in a *comparatively* free and unobstructed manner. The average man is *relatively* free from tension difficulties. When we, therefore, say that the maladjusted individual departs from the average it is not meant in any normative sense as meaning that the average man is such a good liver that

he is a standard to follow, but only that he departs from the mathematical average of the run-of-the-mill of the man on the street. The normal individual, for instance, has his fits of depression, but generally they are not prolonged beyond a few hours and are not very intense. The maladjusted person, on the other hand, has intense and prolonged spells of depression which seriously affect his work. The average man naturally tires, but the frustrated man tires much more easily and with less excuse. The average man has his bad emotions often in the way of anger, irritability, jealousy, and now and then a touch even of anxiety. But the maladjusted individual in contrast is constantly emotionally upset and has a greater emotional intensity than the average man.

F. Departure from the Psychological Norm

The writer cannot complete this chapter without raising the question, "How *should* a person live," even though it is raised explicitly or implicitly in the first chapter. If maladjustment bears the above symptoms then what is adjustment? If maladjustment is undesired, then we must answer the question as to what adjustment is, even though some psychologists should raise the question of how an individual should live. But if the psychologist discusses the difficulty of maladjustment then he is logically bound to offer a standard of living, even though he has to dip into the normative field, which some think is forbidden the scientist. If maladjustment is a constant mental and physiological upset, then the norm in the sense of a standard should naturally be the opposite—a smoothly running and functioning mind and body. This norm is derived from a basic assumption adopted by both the physician and the psychologist by which it is taken for granted that the body and also the mind should function smoothly. If ill-health of the body were the normal thing then physicians had

better forego their profession and take up another occupation. But from the time of the earliest physician, crude though he might have been, up to the present time, every physician has taken for granted that health should be the lot of the human being and ill-health should not be. The same assumption applies to the human mind. If mental ill-health is not out of place then every psychiatrist and psychologist should enter another profession. The assumption that mental health should be the lot of human beings has never been questioned any more than the question of beauty and symmetry of a tree.

But this assumption has even a scientific basis. Herrick¹⁴ says that "normal activity within physiological limits is intrinsically pleasurable." Here we see a very important biological principle, lost sight of by many scientists, namely, that when an act of a human being is unobstructed it contains *within itself* a smooth and easy functioning activity and a resulting pleasure. Herrick quotes the British scientist, Huxley, to the same effect that life possesses intrinsically a spontaneity of action "and its natural expression gives rise to a primeval joy of living." Translating this into free language we may say that the mind of man, from a biological point of view, is made to express itself without frustration and tension. Just as a tree should not be stunted and snarled, so the human mind should not be disintegrated with its result of nerve friction and anxiety. We, therefore, say that the maladjusted individual is a departure from the laws of nature; that to be strainingly and constantly upset is a violation of the norm found in biological functioning.

II. What Is Frustrated?

No student of the problem of maladjustment can obtain a general view of the subject without answering in some manner the question: "*What* is frustrated?" If maladjustment produces such a mental and bodily upset of a more or less permanent nature,

then what is frustrated must be extremely important. We, therefore, as we previously said, spread its meaning too thin, if we include unimportant and minor items as frustrated. We would not include as we said the desire for a clean and uninterrupted nose as frustrated when a mosquito lights on it; nor would we include as frustrated the desire for a piece of bread when we are interrupted in reaching for it by a glass of water in the path of our reach, nor would we include running for a bus and stumbling over a rise in the pavement. A frustration, on the contrary, has to do with the big basic drives of human nature or those great motivating forces that impel us to the task of living. Frustration is linked with our big motives that are the dynamics of living. Starch¹⁵ asked a group of 81 psychologists, "What are the most essential things to know about human nature of people?" And forty-six out of the number said that the most essential thing was motivation, "the forces, drives, motives that turn human machinery." These of course refer to the underlying powers that move us and not the superficial or surface-desires. In discussing, therefore, the kind of thing frustrated, we shall treat: (1) the bodily drives, (2) the vital-social drives, (3) the drive of certain non-vital habits, and (4) the drive to overcome organic inferiority or personal defects.

A. Our Bodily Motives

Since this is primarily a psychological study we will not spend much time in discussing our bodily drives, such as hunger, thirst, desire for rest, shelter and general bodily comfort. When these are frustrated beyond a certain point, death is the result. But even before the frustration has reached this alarming state, the toll of frustration may be very heavy. During the last war and its postwar period many refugees presented tragic evidence of maladjustment because of lack of food, drink, and clothing. These bodily needs are vital in the sense that they must be gratified or death is the outcome. When a refugee is hungry to the point of

despair he may be frustrated in all aspects of his personality. He may not want to work, to plan, to make love, to paint a picture, to engage in companionship, or anything that people ordinarily want to do. The same results may be obtained when one is in a state of exhaustion because of lack of water. We see the same result in respect to the need of rest. When some of our soldiers of the recent World War were driven to continued fighting, they became so befuddled in mind and body, as exhausting fatigue overtook them that undoubtedly breakdowns occurred because of their being blocked in this vital demand for rest.

But some of the books dealing with the subject of frustration have proportioned too much space to bodily drives and left untouched or practically neglected the other big motives of human existence. Most of our soldiers did not break down because of the thwarting of bodily drives. Most frustrated people in a civilian population have sufficient to eat and drink, rest, and shelter and clothing. What, therefore, is of most concern to the student of frustration is the study of what we consider, the vital-social motives.

B. The Vital-Social Motives

What is a vital social motive? It is a drive other than a bodily one that must be satisfied if the individual is to escape social maladjustment or a disintegrated mind. It is one that must be satisfied if we are to get along with people. All writers on the subject agree on this point, whether they think these drives are or are not inherited.

No final authority has been established for the final list of such motives. No two books ever provide the same list, but if one should go through the various lists he would find, perhaps to his surprise, that they number less than ten. Shaffer¹⁶ lists six: mastery, conformity, social approval, security, romance and sex. Maslow¹⁷ lists a hierarchy of drives. Omitting the bodily drives,

he lists in the third level the need for love. On the fourth level, the need for esteem for the self and from others. On the fifth and highest level he lists self-realization, which includes achievement, security, and a sense of belonging to the group. Alexander¹⁸ has two fundamental goals; to be secure and to be adequate. Symonds¹⁹ lists love and hate as two fundamental drives. McDougall's²⁰ list, (later modified), includes sex, curiosity, parental care, flight, gregariousness, self-assertiveness, self-abatement, constructiveness, acquisitiveness, pugnacity, and repulsion. W. I. Thomas²¹ lists security, adventure, and wish for response. Dunlap²² lists amatory desire, parental desire, desire for activity, for pre-eminence, and desire for conformity. Mandel Sherman in a lecture, heard by the writer, listed prestige, security, and activity. MacCurdy²³ lists sex, gregariousness, and ego-expansion.

We have given a sufficient number of lists to show the student that there is no agreement as to the exact number of such vital-social urges. But it is readily seen in clinical maladjusted cases that mastery, recognition, comradeship, security, and romance play perhaps the most prominent part. What most writers intend in giving their respective lists of vital-drives is to name the most *prominent* social drives that govern human life without making the list exact and final. Even a suggestive list is sufficient to show the student why such motives are vital, and if frustrated, may cause a maladjustment.

These drives are called the "social drives" because obviously they have to do with society about us, that is, with our relationship with people. It is in this field that the burden of maladjustment mostly falls. If we get along well with people, there would be little or no maladjustment with the exception of those cases of frustrated persons who are thwarted in getting the bare necessities of life.

A question bound to arise in a class of students taking a course in maladjustment is that of inheritance. Writers are often hesi-

tant to discuss the question, but students are not hesitant in asking, "Are these social motives inherited?" From a practical standpoint it may be answered that it makes no difference whether these social motives are inherited or not, for whether inherited or acquired, they call for fulfillment if a person is to secure an adjustment. Yet the student is saying that if such motives are so fundamental to human nature why are they not inherited, just as the bodily drives of hunger and thirst are inherited and are so vital that maladjustment would lose about all of its meaning should we eliminate them?

Are There Instincts?

In other words, the student is asking what has become of instincts? This is a legitimate question to pose, for instincts at one time were the "talk of the school room." Even the eminent Thorndike of Columbia University, a scientific investigator for many years in the field of education, once said: "Our inherited constitution makes us breathe and suckle and smile and reach for things and walk and be afraid in the dark. . . ." He thus even followed the layman's idea that we are born afraid of the dark. What is now the status of instincts? They have been outmoded, and belong to the museum of sociology and psychology.

What has brought about this change? Simply that the old concept of instinct does not stand the scrutiny of scientific investigation, just as with many other old beliefs. There was a time when both sociologists and psychologists called about anything and everything an instinct without giving it much thought. The consequence was that the concept broke down of its own weight. L. L. Barnard²⁴ in 1924 undertook to investigate the number and the kinds of things which even noted educators called "instincts," and one has only to read his ponderous list to realize that such a "system" had gone too far. Leaving out general things which were called instincts, such as patriotism, he listed 5,684 things of a specific nature named as instincts. Learning had practically

been omitted in the consideration of man's mental equipment.

An instinct was supposed to be an inherited mechanism, possessed by everyone the world over, of a complex nature, ready to function at birth or at the state of maturation. Universality was considered the noted characteristic of the supposed instinct. But when scientific scrutiny was applied to many of the so-called instincts it was found that they did not meet these qualifications. Three chief objections were launched against instincts:

- 1) The lack of universality.
- 2) That what we called instinct was often found to be mostly a matter of learning.
- 3) That the special form of learning called the "conditioned reflex" accounted for a number of them.

In regard to the first, it has been found, for instance, that acquisitiveness is not a universal trait, and this was one always prominently mentioned in the instinct lists. Munn²⁵ says that in a certain Central Australian Tribe for instance there is no acquisitiveness. Everything belongs to the tribe and there is no urge to individually acquire and possess. This is not because the tribe has plenty of everything. On the contrary, water is so scarce that it has to be squeezed from frogs dug up from dry beds of streams. Food is also very scarce and consists of such things as ants, grubs, lizards, and snakes. It was thought that pugnacity is an instinct, but the Arapesh of New Guinea are so mild tempered that gentleness is the general characteristic of the entire tribe. Among the Zuni Indians there is also a marked absence of the pugnacious or aggressively self-assertive attitude (Mead²⁶ and Benedict²⁷).

The second objection is easily sustained, for the so-called human instinct does not include a complex mechanism, a behavior pattern, or the "know how," which was often stressed in the definitions of instinct. We used to think, for instance, of maternal-behavior as an instinct, but any mother knows that she

may not have a pattern of behavior ready at hand to care for the child. In fact, we even find that many young mothers feel helpless in caring for their first offspring.

It is true that an animal, such as a beaver, is provided with a complex behavior mechanism for building a dam—resulting in a marvelous construction but this naturally complex behavior does not seem to appear in the human being. Some may say that the impulse for certain kinds of behavior is innate, but according to the definition of instinct this impulse was supposed to be accompanied by a complex behavior—which is difficult to prove for human beings, save a few reflexes.

But the most telling onslaught against instincts is the conditioned reflex, sponsored principally in this country by Watson.²⁸ Take, for instance, social approval or the desire for recognition, one of the vital-social drives included in about all of the instinct lists; this is explained as arising in a purely mechanical way from the mechanism of the conditioned reflex. The mother gives the milk bottle to the baby, providing it comfort and satisfaction. The milk is the unconditioned stimulus and the satisfaction the response. But Mamma is the incidental accompaniment of the milk bottle. She just happens to hand the milk bottle to the baby, and thus becomes associated with the milk bottle as the conditioned stimulus. Mother naturally showers her love upon the baby. Since the baby comes to like the milk bottle it also comes to like the praise and love of the mother, incidentally associated with the bottle. So this is the way the urge for recognition is acquired, say the exponents of the conditioned reflex. It is a purely mechanical acquisition. If other than a mother had been present in feeding the baby and giving it love, say a giraffe, the baby would come to look for love and praise from the giraffe.

Dependence is also explained in the same way. Since the baby comes to depend upon the bottle it comes to be dependent on that which is incidentally associated with the bottle and this happens

to be Mamma and so the baby learns to be dependent upon its mother—another pure mechanical acquisition. The most frequently used illustration of the conditioned reflex for the developing of these basic motives is the urge of gregariousness. This too was always included in the list of instincts. Seldom would anyone during the height of "the run" of instincts deny that gregariousness was an instinct. But the conditioned reflex exponents claim to have rescued this also from the folds of inheritance. It is said that the baby grows up wanting to be with people simply because they happen to be around when it was fed. People being around was the conditioned stimulus associated with feeding or the proverbial milk bottle, and since the baby wanted to be around milk bottles it wanted to be around that which was incidentally associated with milk bottles. If anything other than people had been around milk bottles when babies were being reared they would have acquired an urge to be with them.

Now we are beginning to think that we may have been too hasty in discarding inherited drives for the human being. Some now are realizing that the psychology of change has misled us; that when the pendulum swings from one extreme it goes too much to the other extreme. So some are bringing back the word "instinct" but modifying its definition to allow for the great play of learning. What they feel is that the old definition overdefined an instinct, and that if we could look upon it as one native *undeveloped* urge necessitating much learning to perfect it, then we could restore the term. If hunger for the baby is just undeveloped urge, necessitating much learning in order for the child to know where and how to get and eat food, then it is thought that we could have native potential psychogenic or social drives, not perfected mechanisms at birth, but necessitating the addition of much learning before they usefully function.

So the conditioned reflex itself has come in for a little criticism. Writers who explain the creation of social drives out of the

mechanism of the conditioned reflex are said to violate the cardinal rule of logic, namely, a generalization should only be made from a great many instances. It may be true that gregariousness, dependence, and social approval are generated from the conditioned reflex, but it is said to be a hasty generalization to say that *all* social drives are derived from the conditioned reflex. Let us take, for instance, one of the fundamental drives proposed by Alexander as mentioned above, namely, that of the need of adequacy which he says is a desire for self-realization and independence. It is difficult to see that this urge for independence could ever have developed from the conditioned reflex or from our proverbial milk bottle, for the reflex itself is supposed to develop only dependence. Then it is hard for some to see that such urges as the urge to paint, to seek out beauty and immorality can ever be derived from the conditioned reflex. Many things we want apparently were not ever associated with the conditioned reflex. Barnard says that nothing is an instinct unless it has a "concrete neurological standpoint," meaning that it must have a definite neurological basis, such as thirst having its basis in the throat. But it is difficult to see that an artistic urge of a Bach has such a corresponding definite neurological basis.

Other derivists of social drives, such as Schaffer,²⁹ say that mastery is derived from anger, a native reaction proposed by Watson, but mastery here means domination. But most people define mastery as achievement and this hardly can be derived from rage. Shaffer also says that conformity is probably derived from fear, another native urge proposed by Watson, but it is also possible to consider conformity arising from the desire to belong and not to be a slave to the dictates of society.

After this discussion, the student may feel justified in a reluctance to forego inheritance as the basis for some of our social drives. The word, "instinct," may enter again into our psychological language, although in much altered form.

C. The Non-vital Drive of Habit

Certain habits may constitute drives as powerful as our basic social urges, yet they are not vital in the sense that they must be fulfilled to bring about an adjustment. They are not essential to maintain a mental economy, but when once acquired they may become so demanding that a constant barrier against which there is no convenient escape might result in a syndrome of frustration symptoms. An old belief may fight against a new belief; a fanaticism for routine may be frustrated by disorder; rebellion against authority may fight against authority; and an urge for quietness may be constantly fighting a barrier of noise and dissention. These are quite different from the social drives. We need companionship to get along, but we do not need to adopt a conservative belief which may get us into difficulty. We need mastery in the sense of achievement or success, but we do not need an overwhelming urge for routine. We need romance to round out our lives, but we do not need a rebellion against authority to get along. We need recognition to keep up our esteem, but we do not need an unusual yen for quietness to bring about a well-balanced life. Yet these non-vital habit drives are for many people serving as a basis for a disorganized mind and a maladjustment.

We can well understand this principle, by means of Woodworth's³⁰ idea of "functionally autonomous" habits. A behavior mechanism may be adopted to serve a basic motive, but once it is established it does not need an internal stimulus or the original motive to set it going, but it may be released by an outside stimulus. A person, for example, is brought up in a very conservative family and trained in a very conservative, religious belief. The latter may be adopted to serve the motive of social approval of the community, but once the belief is firmly fixed it may continue to function of its own accord even though the person has

become liberally minded and the old need of companionship and social approval of the community does not apply, for he may have moved into a liberal neighborhood. A young lady walked into the writer's office one day "torn within," wanting help for her difficulty. Enquiry revealed that she was brought up in a certain strict religious faith which forbade dancing, card-playing, going to the theatre and other commonly practiced activities. At the age of twenty she began to read all sorts of liberal books unknown to her parents and minister, took a class in problems of adjustments, and in two or three years had completely withheld intellectual assent to her old belief. But she was not at ease. She would go to other churches which did not believe in restrictive recreational measures, but she kept going back to her old church and old associates. She felt at home in neither the liberal nor the conservative church, and after constant worry she finally found herself a "nervous wreck." This sort of conflict comes under the second kind mentioned by Lewin. She wanted the new faith, but the old faith pulled her back. She developed a conscience for the new faith but she developed a stronger conscience for the old. Her old belief was automatically set off whether she wanted it so or not when she saw her old friends and her old church. The continual strain between the new and old faiths set up a constant emotional state resulting in mounting tension and depression. When she realized her problem she so strengthened her new faith that it superseded the old so as to put it in the background.

A chronically disturbed veteran was assigned to the writer as a psychoneurotic case. He had been an artist and had played the French horn in one of the leading orchestras of the country. He had been in excellent health before being drafted into the army, but after a year in the service he became a problem case of nerves and developed a fear of playing his French horn and would not play it. He was a meticulously dressed individual with very precise and feminine manners. Examination showed that he rebelled

against the rough routine and inconveniences of the army. During his battle days he spent days upon days in mud with a muddy uniform. The rough army life served as a barrier to his fanatical devotion to cleanliness. So deeply engrained was this urge for cleanliness and order that there was a constant battle between himself and the entire army regimentation. The strain at last caught up with him and he was sent back to the States for a new assignment. This too comes under Lewin's second kind of conflict. There was more to this case than a strong urge for cleanliness being frustrated at every turn, but the principal difficulty was his terrific battle against dirt. His urge for cleanliness served at first the motive of cleanliness itself but it finally became a drive on its own right without serving its original motive.

The man brought up with a stern father rebels against him to save his self-esteem, but this mechanism finally provides its own drive and whenever he confronts any kind of authority he sets up a rebellion even though the stern father is no longer in the picture and the new authority confronting him may be benign. He becomes so maladjusted to his environment that he cannot hold a job because he vents his rebellion against any sort of instruction. He even marries a clinging vine girl to make himself the only home authority even if he is not happy with her.

A person adopts the habit of seeking unusual quietness to satisfy the motive of mastering his lessons, but it becomes so strong that it finally dominates him. Even after graduation and lessons are out of the way he keeps up the urge. It becomes so functionally autonomous that he demands unusual quietness in his office when it is not necessary. The battle between himself and innocent distractions keeps him in a constant lather. He wants unusual quietness but environment presents a constant barrier. This too comes under Lewin's second conflict.

Habits of a non-vital nature may cause as much unhappiness as the frustration of important, social drives.

D. Frustration Due to Personal Defects

What is frustrated when one is humiliated because of a personal defect? Alfred Adler³¹ first emphasized the case of the child frustrated by an organic inferiority which leads him to develop the drive for power or superiority. Adler did not emphasize this as much in his later works, but in his earlier writings he cites cases of children charged in court with all kinds of evil—theft, cruelty, stubbornness, sexual perversion, and many other serious demeanors, and in most of them brought to his clinic for treatment, he found some kind of serious bodily defect, weak eyes, decayed teeth, bad digestive system, deformities, degenerated inner organs, diseased tonsils, adenoids, and many others. He claimed the motive for delinquency often lay in frustration on account of a personal defect. The children strove for power to compensate for their feeling of inferiority.

While Adler might have overstated his case, personal defects play a big role in frustration. What is frustrated by a personal defect? Surely one may be successful with a personal defect, receive social approval, recognition, and marry and rear a family, but all this may not satisfy him. His self-esteem may be injured and he may have, therefore, a profound general degree of inferiority. This urge for self-importance is very important and shows itself early in our lives. It was seen in the Dionne quintts as told by Dr. Dafoe, their physician. Dr. Dafoe tells the story of the girls being given their baths one morning and little Marie being last. When she was placed in the tub she thrashed about in rebellion until they had to remove her. The suggestion was made that on the next day she be given her bath first. There was instantly shown a great change in her behavior. She instantly displayed a love of the water and they had difficulty in getting her out of it. In her childish consciousness she felt that to be placed last was an affront to her pride. So with a personal defect our general pride may be hurt.

The defense mechanism of real compensation is adopted chiefly because of personal defects. In general these takes three directions: (1) in the line of the defect itself, (2) in a line other than the defect, and last, (3) in the line of domination or power. In regard to the first direction, we see it well illustrated in the life of Glenn Cunningham, who had his legs burned so badly in a school fire that the physician said that he could never walk well again, let alone run on the school track. But he became the best miler Kansas University ever turned out, and the greatest in the country. In regard to the second, we see numerous examples of creativeness that appear to balance in their minds the loss of self-esteem because of personal defect. Steinmetz, very much deformed, became a genius of invention for General Electric, and those who knew him felt that much of his inventiveness atoned for his lack of a sense of personal worth due to his deformity. It is said that Edison would not have become the wizard of Menlo Park were it not for his deafness which made him feel out of things in regard to human communication. The organ composer, Bach, felt that he lacked something because of his difficulty in meeting and holding his own with people, but he made up for it by finding his pride in becoming famous as a musical wonder.

Someone has called inferiority the "golden complex" because out of it has risen a challenge to work fanatically for success and as a result we have some of our great novels, our great paintings, and our great plays. Some say that if not for frustration we would be deprived of many of the great products of civilization. This is very true, but it must not blind us to the fact that these people created under great stress and suffering, and their fight to restore their self-esteem was through the torture of frustration. We cannot because of this say that frustration is necessary for creativeness, for many of our wonderful art creations were produced without frustration. All we can say is that frustration did serve as a challenge just as pain served as a challenge for Robert Louis

Stevenson to rise above suffering and make a contribution to the world of literature. Certainly no parent would ever frustrate a child in order to make of him a genius, or purposely inflict a personal defect to serve as a challenge to greatness.

Then often a personal defect may serve the very opposite of constructive endeavor and produce an anti-social tirade leaving in its wake suffering and futility. In studying the life of Napoleon it may be concluded that he felt humiliated because of his small stature and his striving for power was partially explained because of his sense of inferiority. He felt an inferiority because of things other than his small stature, but his desire for domination, especially seen when he magnified his weight and height by riding a big white charger, was much influenced by the smallness of his person. If he had been a big man he might have sought less power. An abnormally small height may produce a wit, but it also may produce a tyrant.

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THE AGGRESSIVE FORMS OF THE DEFENSE MECHANISMS

By

HOWARD R. WHITE, Ph.D., Chief Clinical Psychologist
Veterans Administration Medical Teaching Group,

II. Definition of Aggression

We will first of all, make a very preliminary procedure to simply to
state the main line of thought of the individual and thereby state
behavior as aggression or nonaggression. We will then go on to

THE AGGRESSIVE FORMS
OF THE
DEFENSE MECHANISMS

BY ARTHUR S. WINTERS, JR., and
JOHN H. HARRIS, JR.

Chapter V

THE AGGRESSIVE FORMS OF THE DEFENSE MECHANISMS

By HOWARD R. WHITE, Ph.D., Chief Clinical Psychologist
*Veterans Administration Medical Teaching Group,
Kennedy Hospital, Memphis, Tenn.*

I. Aggression Tendency Like Other Tendencies

In the following chapter we shall present a survey of the way in which aggression manifests itself in the behavior of the individual. We have a definite prejudice of which the reader should be made aware. While it is important to be able to recognize aggression as a separate response, it is even more important to recognize that it behaves dynamically exactly as does any other conflict area. We understand personality as a dynamic organization characterized by continuity and a sense of personal identity but beset by the inevitable compromises that are produced by many drives proceeding toward related but not identical goals.

We have attempted to survey the experimental literature with sufficient detail to afford the student an adequate background with which to think for himself concerning the role of aggression in the structure of the personality. It is hoped that he will be challenged to pursue further some of the references cited.

II. Definition of Aggression

We will find it a very unsatisfactory procedure to simply observe the manifest behavior of the individual and classify that behavior as aggressive or non-aggressive, or, as showing or not

showing value as a defense mechanism. We quickly realize that all defense mechanisms represent a challenge to the world, a refusal to accept its demands. We are forced then not merely to observe the behavior acts of the individual, but also to ascertain their meaning to the individual before we can effectively classify them or predict future behavior from them.

Our problem of defining aggression has already been complicated. It may be violent or antisocial behavior, or at the other extreme there are situations in which apparent withdrawal is essentially strongly aggressive. Thus, one cannot assume that the child huddling in a corner is not being aggressive unless one also assumes that the child does not hope to force his parents to show him an extra measure of affection. In adult life, one cannot assume the lack of aggression in a mother who "sacrifices everything for her children" until one has also demonstrated that she does not use that "sacrifice" to control those children (or their father).

It has already become apparent that we think of aggression not as an entity but as describing certain types of behavior. Freud¹ has suggested that aggression or hostility may be expected to be directed toward those factors interfering with the pleasure principle. In later writings,² he further suggested that it is a component manifestation of the death instinct, that, in brief, we must all show aggression because of our innate structure even though the external events may not evoke frustration. Dollard and his co-workers³ have stressed the role of frustration in producing aggression, although subsequent work has suggested that not all frustration will evoke measureable aggression.

It is suggested that we understand by aggression those attitudes and behavior acts through which the individual seeks to attain his own goals without giving essential consideration to the rights and needs of others. It would be expected to be characterized by a tendency to attack others either directly or symbolically. It

may be directed outwardly against the world or become manifest in internalized conflicts such as Dunbar⁴ suggests underlie certain psychosomatic disorders. It is also to be recognized that the observable behavior of the individual is a compromise of many competing drives. For this reason, it is quite possible for behavior which is essentially aggressive also to be activated by non-aggressive motives.

In such a definition we are not attempting to pass a moral judgment but rather to abstract an aspect of our adjustment mechanisms so that we may more clearly understand behavior. Since the individual is concerned primarily with his own interests his behavior will frequently, though not always, be anti-social. There are times when it is desirable for the individual to display aggression for his own welfare and to further his own maturation. Thus a child who is over-protected by his parents can mature only when he can become active in seeking his own goals even though this may bring him into conflict with his parents. It is necessary that the individual learn properly to utilize aggression. Alexander⁵ has suggested that only those frustrations which leave no hope of solution and are, therefore, wholly destructive in their effect should be eliminated. We may even go beyond the individual and suggest that there are times when society as a whole may gain more than it can foreseeably lose from certain aggressive reactions of the individual, but these questions are separate from the classification of the behavior of the individual as essentially aggressive or non-aggressive.

We have already suggested that personality structure in the human is a partially but not a fully integrated system. Our behavior is not an expression of a single drive or motive, but of a balance between many drives and motives. A husband is devoted to his wife, but he hesitates to embrace her in public gatherings. He loves his children with equal devotion, but there is a difference between the love for the wife and the love for the chil-

dren. His "devotion" in each case is not merely love, but is colored by other factors such as his attitude toward authority as manifested toward the children or as he projects it into the wife. By the frustrations and satisfactions that he has encountered in his relations with the wife or the children, all of these elements enter into the composite we designate as devotion. Similarly, when the individual behaves aggressively, he may be primarily oriented toward his own goals and objectives, but he cannot consistently or completely maintain such an orientation.

III. Defense Mechanisms

A. Socially Approved Aggression

Aggression is intimately associated with the defense mechanisms. It may be a result of an unsuccessful defense, or it may utilize a defense mechanism for its expression. This association must be recognized whether we think of aggressive behavior as resulting from an instinct or as evoked from frustration.

In our society we are ambivalent toward aggression. There are many socially approved manifestations of it, but there is equally strong disapproval of its manifestation in other situations. The individual who displays aggressive behavior must meet the consequences of his aggression both in the world of reality and in his own psychological world. If the aggressive behavior is acceptable at both of those levels, we would not expect to encounter the use of a defense mechanism. Such a situation would be true for socially approved aggression adequately utilized in the case of the student who successfully masters his course not merely because it lies in the area of his interests, but primarily because it affords one means of demonstrating his ability of proving his intellectual stature and thus perplexing those who underrate him. There are even situations in which unsuccessful aggression would not be expected to evoke a defense response. Here would lie those

situations where the aggression was in response to an environmental press that has ceased or to the press of a drive that has subsided. We would expect that the press had not seriously threatened the personality structure if failure of the aggression was still acceptable. However, if the personality structure had been threatened, we would expect to find a defense mechanism utilized and would expect to find the later behavior of the individual to appear unreasonable in those situations symbolically equated to the unsuccessful aggression. Thus, the psychotic individual may at times reflect apparent apathy, and at other times respond with marked aggression that does not seem related to the environmental situation in which he is at the moment of expressing his aggression.

We expect that some use of the defense mechanism will be inevitable in those situations in which the individual finds his aggressive behavior unacceptable to either the world about him or to himself. If he did not attempt to build a defense, the integrity of his personality structure would be definitely threatened by the conflicts he faces.

Recourse to defense mechanisms is not always a successful answer to the conflict. When it is adequate to meet the problem, we may expect the individual to continue to react without further difficulty, but more often it is only relatively adequate, and the future behavior of the organism is distorted in terms of what is basically a still unsolved problem, or rather, for that individual at that time, a still insoluble problem.

B. Defenses Against Aggression

It is worth our while to review briefly several of the major defense mechanisms and consider how they may be used to handle unsatisfactory aggression, but we should not lose sight of the important factor: not their description, but rather their purpose. We do not expect to find the use of only a single mechanism in

the individual faced with a conflict. We expect, rather, that he will make use of any defenses available to him to resolve his immediate problem.

1. Substitution

One of the classic defense mechanisms, *substitution*, may be considered by definition as a relatively adequate means of handling the aggression, since here the basic drives find a satisfactory outlet, although a different one from what they would otherwise have obtained. The aggression may still be present (it is not a sure sign of maladjustment to show aggression), but it has been deflected into behavior acceptable to the individual and to the world about him. Such a solution is available only to a rather well integrated personality that has strong affectively toned ties with the world around him. If the mechanism is relatively successful, how can we know it is used? The answer lies in its relative success which still leaves sensitized areas. I may sublimate my aggression against a fellow psychologist by writing on the topic of aggression and so remain on the best of terms with him, but if he suggests that that is my reason for writing, my defense is threatened, and I may be expected to show inappropriate affect, probably using a different mechanism to protect my original defense.

2. Repression

Anna Freud⁶ has suggested that *repression* has a special value in combating sexual wishes and would be less readily employed against the aggressive impulses than would other forms of defense mechanisms, but the importance of aggressiveness and passivity in the working out of the sexual role would lead us to expect repression to be utilized as a defense mechanism for at least certain aggressive behavior. Thus, we find frequent reference in clinical studies to the repression of the sexual aggressiveness

displayed during childhood, the individual remaining quite unaware of the behavior until he is able to accept it as a consequence of some therapeutic process enabling him to cope with problems that have been insoluble to him as a child.

3. Denial

If the conflict area is relatively isolated, it is possible to handle it by simple *denial*. In the adult one sees fragments of such a mechanism in the daydreams of success or inability to recall aggression that one is alleged to have committed. A simple example would be one's denial that he has crowded in ahead of other people waiting to board a bus even though he might be able to recognize that he did get on first. In such an isolated case, the mechanism may successfully contain the aggression. It is not adequate to handle conflicts that spread over a greater area of behavior without risking memory losses or contradictions of reality that would defeat its purpose, since they would not be acceptable to the world even if they were to the individual. If the use of the mechanism of denial is carried beyond the limits acceptable to the world of reality, we are faced with a psychotic personality structure.

4. Incorporation

In a greater or lesser degree, we fail to distinguish between ourselves and the world in which we live. All of us experience this in part when we distinguish our possessions, for example, our new car or favorite pipe, from the identical object turned out by the same process but in the possession of another person. The one, ours, somehow seems better than the other, and the longer we have it the more this seems true. Emotionally, and to some degree intellectually, we extend ourselves beyond the realm of the thought that we are to include not only our physical bodies, but also to include to a lesser degree those parts of the external world with which we have the most intimate psychological rela-

tions. This makes it possible for us to display two contrasting attitudes toward our environment. On the one hand, we can *incorporate* that toward which we are aggressive and so render our aggression acceptable. Thus, the father who insists that his son must not consider music as a career but must become a doctor feels fully justified since it is his son. He feels justified in resenting the suggestions of an "outsider" that the son's interests and abilities should be considered, and equally feels that the son should acquiesce. Or a similar example, the parent may feel justified in spanking the child but would not delegate the same "right" to anyone else responsible for the child's behavior. Our aggression has become acceptable because it is thought of as not really being aggression against the world. We regard it as our own treatment of our own being, and the world in which we live need not concern itself about it.

5. Projection

We can also utilize the vagueness of the boundary between the self and the not-self in another way. We can render our aggression acceptable by *projecting* it outwardly. We may admit that we pushed people aside to get on the bus, but the point is, we insist, that they started it, we were waiting our turn, and they tried to crowd in ahead of us. Essentially, we are trying to say that it was others who were aggressive, not ourselves. The mechanism is used by the extremely maladjusted as well as by the normal. Thus, a schizophrenic patient with a homosexual conflict complained that women were not to be trusted, that they pursued him, and then they deliberately tried to make him look foolish. Not only did he project his sexual conflict, but the women who "pursued" him could do so only when he went to a recreation ward and sought them out. He was the aggressor but could not accept that role. Wright⁷ reports that projection can occur only in those conflicts where anxiety is present. One should distinguish between use of a defense and projection on the basis of

non-affective experience where, for example, we act aggressively only because we do not understand the situation. Thus, we may act aggressively toward a stranger who is trying to help us until we perceive his intent. Here the personality structure need not be involved, and our behavior is not explained as utilizing defense mechanisms. When such a situation is finally clarified, we do not show abnormal affect, and there is no residual anxiety. It is only when the integrity of the personality is at stake that the anxiety would be present, and only then that any of the defense mechanisms would be needed.

6. Reaction Formation

One can attempt to handle unacceptable aggression by *reaction formation*. Here we find the militant pacifist who struggles aggressively to prevent aggression. Certain highly regarded benevolent projects would never have been carried through to their desired goal if it were not for people who, unable to accept the thought of their desiring to control their fellow men, find outlet for their aggression in projects devoted to the general welfare, thus "proving" their own freedom from aggression. The cue which justifies our thinking of their behavior as defense, is again the unneeded affect and vigor with which they would deny the possibility of unrecognized aggression in their behavior.

7. Undoing

Closely allied is the mechanism of *undoing*. Here the aggression may be formalistically denied by later behavior. The social history of our country shows many examples of enterprising, aggressive men who later denied their aggression by means of major gifts to society, and the same pattern is reflected on a smaller scale by many other people. The undoing may also be achieved by repeating the original aggressive behavior pattern without any aggressive intent, thus "proving" that it really was not aggression in the first place. One may speculate to what degree we are using

this mechanism in some of our institutionalized forms of discrimination against minority groups. Clinically, we encounter the mechanism in the compulsive person who sets up a ritual to disprove his aggression. If the defense structure cannot contain the aggression, we will find him broadening the ritual to cover larger and larger areas of his behavior. At times he finds it impossible to accept even normal aggression and may encrust his ordinary statements with attestations of his love of his fellow men when such testimony is foreign to the essential content. The effectiveness of this defense mechanism lies in the degree to which the individual can accept the testimony of his overt behavior as evidence that he really was not showing aggression in the first place.

8. Isolation

It is also possible to lessen the impact of the unacceptable aggression on the personality structure by psychologically *isolating* it from the rest of the personality. It then becomes possible to treat it as if it were of no importance although the displaced affect will reveal itself by appearing, apparently inappropriately, on other material. Thus, the school child, unable to express his aggression freely at home, will find himself unable to discuss his school activities at home. He has kept the two areas separate from each other, and his behavior in the one situation is not thought of as requiring the same standards as are demanded in the other. We are not faced with the child who deliberately fails to report a single event at home, but rather with a child who reacts to home and school as two separate worlds that do not overlap with one another. In adult life, we have the "Sunday-Christian" whose religion is not an integral part of his personality, but who may practice it intensely one day a week and ignore it the other six, permitting himself aggressions against his fellow men that he would never condone on the one day.

9. Turning Against Self

Anna Freud⁶ characterizes as a more primitive defense mechanism the tendency to *turn against the self*. Thus, aggression may become masochism, the punishment that one inflicts upon oneself serving as a proof that he harbored no aggression toward others and as a punishment for thinking that he might. Clinical evidence supports the obvious conclusion that sadism and masochism are dynamically intimately related. In the sadistic reaction, the guilt for the aggression is projected outwardly to the other individual, who must be punished to prove that he and not the sadistic individual is guilty of aggression.

10. Regression

Regression is another of the more primitive solutions. Here, instead of attempting to recast the conflict underlying the aggressive behavior into an acceptable form, the individual retreats to a less mature level of development where the conflict did not have to be met.

In outlining the defense mechanisms, we have deliberately cast them into the changes that are to be expected in the aggressive forms of behavior. We have oversimplified the picture in doing so, however. At the same time that the individual is attempting to render his aggression acceptable to himself, equivalent changes would be expected in other dimensions of personality. Thus, the psychoanalysts⁸ have stressed the changes that occur in the cathexes of the individual, particularly as related to the sexual component because of its special role in our cultural pattern. The whole picture is still more complicated, however, as we have already indicated the individual does not seize upon one defense mechanism as the solution of his conflicts. He utilizes whatever mechanisms there may be available to him which will offer a means of making the conflicting materials acceptable. In certain areas of his life he may show a high level of maturity, since these

areas are free of unacceptable affect, while at the same time he may show severe impairment of the personality structure in other seemingly closely related areas. Clinically, it becomes important to appreciate the patient's system of relative values in order to understand his utilization of the defense mechanisms to handle behavior tendencies he experiences but which are unacceptable to him. If we are going to assist him in integrating his personality, we need to understand not only how he is defending himself, but, also, what it is that he is defending himself against.

IV. Experimental Literature on Source of Aggression Instinctive or Acquired

One of the basic problems with which we are faced is a determination of the source of aggression. Thus we find in the writings of Nietzsche, Freud,² and more recently in the writings of Karl Menninger⁹ the belief that aggression is a manifestation of a universal "instinct," while others, such as Dollard,³ conceive of aggression as a defense mechanism against frustration and insecurity. Still others join Maslow¹⁰ in a middle ground, feeling that they find the demonstration of instinctive aggression in some animals, but that the evidence for an "instinct of aggression" becomes weaker the higher one goes in the phyletic scale.

As an example of "aggressive instinctual behavior" the study of Yerkes and Bloomfield¹¹ has been cited. While they found that kittens do kill rats, more recent studies have served to modify the interpretation that we have thus demonstrated any instinctual behavior. Thus McDougall and McDougall¹² found kittens would kill wild mice but at the same time not kill the white rats with which they were caged. Kuo¹³ found an increase in the tendency to kill rats after the kitten had seen another cat kill a rat. More recently¹⁴ he has found that kittens raised with rats as cage mates did not tend to kill rats like their cage mates, even after seeing another cat kill a rat. However, they would frequently eat

a shaved rat or the young of the cage-mate rats.

Winslow¹⁵ has conducted a series of investigations into the social behavior in cats. He finds that under some circumstances competition may reduce running speed, with aggressive behavior being directed by one loser against another. In another situation¹⁶ where both competitors have access to food the competition brought about more rapid manipulation, and even some sharing of the reward without aggression.

Masserman^{17 18} finds that if a "dominant cat is forced to yield its supremacy in a food getting situation to another cat he will become definitely aggressive, particularly toward the newly dominant cat, and further he finds that if the cat is then permitted to dominate the situation again, this aggressivity is diminished as the original food-oriented behavior becomes re-established. The aggressivity then is a direct function of the stress and frustrations to which the animal is submitted.

Seward¹⁹ has found that the pattern of aggressive behavior in the rat changes with aging. The number of aggressions tended to drop, although the intensity and decisiveness of the behavior in an aggression tended to increase. This trend was more conspicuous in the male than the female. (Might one speculate that like their human counterparts, female rats strive to conceal their true age?) Klee²⁰ studying frustration and motivation finds evidence to suggest that the behavior of the rat is determined not only by the present stimulus but by its previous experience. He concludes that frustration of behavior is more important than merely the emotional shock in determining the abnormal fixation of the behavior. He also suggests that the degree to which the animal is involved in the situation is a significant factor.

McCulloch and Haslerud²¹ report observing some aggressive behavior in chimpanzee reared in isolation as early as the seventh month. However, they report that on the whole very little of the behavior was describable as aggressive. At the age of fifteen

months there was an increase in the aggressive behavior (and in avoidance behavior) and it was elicited by a wider range of stimuli.

The experimental literature on aggression in children reflects the same duality of approach that we found in animals. There is considerable awareness of the presence of modifying factors, but some investigators feel that they are faced with an innate drive,²² while others would stress the role of frustration in eliciting aggression.

In a paper delivered before the American Psychiatric Association in 1948, Bender²³ stresses that the child's approach to life is a normal one, with hostility developing as a consequence of frustration of drives for normal biological maturation, for social identification and articulateness of the inner fantasy life. The Cushings²⁴ at the same meetings reported finding movements which they characterize as being "aggressive defensive movements" in the fetus of 20 weeks.

The pattern of aggression is greatly affected by the cultural pattern. Devereux,²⁵ in commenting upon infanticide among the Mohave Indians, makes clear the lack of identification of the mother with the infant after birth and before she begins to nurse it. Devereux feels that at this time it becomes possible for a deserted mother to displace her aggression from the father to the child. Moloney²⁶ has been impressed by the stability of the personality patterns he encountered on Okinawa Shima, and has suggested that it is related to the nursing pattern during infancy, a pattern which would serve to lessen the need for aggressive behavior on the part of the infant. Such a pattern is in sharp contrast to the Dobuan culture described by Benedict²⁷ where hostility and aggression are present from the earliest life.

In our cultural pattern the child is faced with a difficult problem to handle in that the parents serve both as his closest love object and at the same time as the central figure of authority

limiting his activity. It has been suggested²⁸ that this difficulty in identifying with the parents because the child can neither freely love nor freely hate them may be one of the bases for the frequently observed pattern of conflict in the pre-school years. Such conflict would be expected to reach a peak at three since the newly acquired skills of walking and talking provide more situations when the adult is apt to frustrate the child by limiting his behavior. It would further be expected that there would be another peak in conflict at adolescence since the sexual maturity would reactivate the conflict implicit in the dual role of the parent as love object and as disciplinarian. Dennis²⁹ finds that among the Hopi the aggressive patterns are rather similar in form and origin to those of our culture. However, the Hopi child does not usually show fear or resentment of the father, apparently because the maternal uncles assume much of the disciplinary activity.

Murphy³⁰ has suggested that the effect that such cultural patterns as the ambivalent status of the parent in our society will depend in part upon the child's developmental history. Thus, one would expect a child who has been handled permissively to find a suddenly imposed tabu more traumatic than would a child who has previously made some adjustment to privation. It might also be hypothesized that a child who had perviously been unable to make some adjustment to a privation would be more affected by an additional privation than would the child who had previously made some adjustment. We should also recognize that the tabus on aggression are not usually all-inclusive but tend to be limited to certain varieties of aggression. Thus the parent may tolerate the child's "talking back" to another child but not tolerate the child's "talking back" to the parent or the child's hitting the other child.

Murphy has further suggested that the principle of transfer of the pattern of aggression developed in the home is implicit in the

theories of Freud (substitution) and Adler (compensation). This type of behavior has been experimentally demonstrated by Anderson³¹ to occur in the first grade, where the pattern of aggression developed at home is transferred to the child's school behavior. Altschuler and Hattwick,³² working with easel painting, find there is a high degree of individuality in the transfer. Such a finding would be in keeping with Shirley's³³ study of the first two years. It is, of course, implicit in our concept of aggression as a manner of behavior, dynamically determined, rather than an entity.

Aggressive behavior becomes manifest early in life. Whether or not we agree with interpretations suggesting that it is to be found in prenatal life, the work of Marquis³⁴ indicates that aggression is apparently present in the first months of life. Apparently the physiological drives are important determiners of the aggressive behavior appearing at that time. Greenacre³⁵ has suggested that it is not merely restraint of activity but rather restraint with a lack of a positive relationship that induces aggression.

Beaver³⁶ reports that the number of aggressive contacts tends to increase with age. Among others, Bender and Schilder³⁷ report that there is a tendency for younger children to express aggression more overtly, while the older groups are apt to be more inhibited. The older children are apparently more apt to use verbal than overt aggressive behavior. Dynamically important is the finding that aggressiveness against a group is easier to experience than aggression against an individual.³⁸

The family structure plays an important role in the appearance of aggression, even within the cultural pattern. Goodenough and Leahy³⁹ report that as a class, only children tend to display aggressive behavior. They found that oldest children tend to lack aggression more than middle children, while the youngest children showed no marked lack or excess of aggression. Related to

this are Hattwick's⁴⁰ findings that children whose homes reflect overattentiveness are liable to display infantile withdrawing types of behavior. At the same time homes reflecting underattentiveness are apt to result in a display of aggressive behavior reflecting insecurity. Fite⁴¹ has demonstrated that the child's attitude toward aggression reflects the rules laid down by his parents and the relation of these rules to the corresponding standard set by other symbols of authority in his community. The work of Lewin, Lip-pet and White⁴² would suggest that even this relationship is conditioned by the degree to which these symbols of authority exert their pressures without considering the attitude of the child. In general, the more the authority is imposed the less overt becomes the aggression toward the authority and the greater the aggression toward other individuals.

Sears,⁴³ in a study of aggression as shown in doll play, has found that boys tend to be more aggressive in homes where the father was present than in those homes where the father was absent. He also found them to be more aggressive toward the father than toward the mother. The same factor was not found for girls. The pattern of aggression changes with increasing age toward a more socially approved one. The same effect is noted when different levels of intelligence are compared. It is normal to our culture to display some aggression, however, and the children who are most socially active will display the most aggressive behavior, partly because they have the most opportunities.

Wright^{7 44} has found the social pattern to be important in determining the response of the child. Generalizing from his studies we would expect more cooperative behavior and more aggression against the frustrating factor when the frustration is shared by strong friends. This would suggest that the increased security brought about by the social interaction reduces the influence of the frustration. Apparently the stronger the frustration experienced the less constructively the individual could meet his problems.

It is not only in the role of interpersonal relations that we have found an understanding of aggression. There are suggestions of developmental patterns having their roots in constitutional factors such as strength, health, and tissue needs as well. There are patterns in the development of expression of aggression with increasing tendency to verbalize and to socialize the expression of aggression. The amount of aggression and the manner in which it may be displayed is also determined by the relations with the parents, and the degree to which the environmental pressures are felt to be constricting by the individual.

As we turn to a consideration of the adult, we would expect to continue to find an interplay between constitutional and environmental factors. We would expect the same dynamic relationship, but we would expect a further increase in the role of the environmental press.

Goldfrank⁴⁵ suggests that this may be found in a whole cultural pattern. He reports that the Teton Dakota showed a frequent incidence of in-group murder prior to 1850. This was during a period when wealth was unevenly distributed. There followed a period of nearly thirty years when the arrival of the white men brought about a decrease in in-group aggression and the appearance of group-solidifying institutions. After peace with the whites was finally concluded, however, in-group murder reappeared.

Apparently Stagner^{46a, b} has encountered a similar change in the direction of aggressive behavior consequent upon a war situation. He finds that his scales of attitudes toward war and the use of violence show little relation to the scores obtained in peace time and feels that his data indicate the use of a new frame of reference. That such attitudes are not only determined at broad cultural levels is indicated by his further finding that his active radicals have less satisfactory relations with their parents and lower personal morale (self-satisfaction). He makes an important distinction between the direction of aggression and the degree of

aggression, finding his men of good family morale tending to be conservative, nationalistic and aggressive. Unfortunately we do not have an adequate clinical basis for determining whether the report of good relations with the parents was factual or a defensive measure, a distinction more important for the clinical understanding of the dynamics than for Stagner's particular problem.

Brown⁴⁷ has studied the external frustration and wishes experienced in adjusting to army life and suggests that here there is no endopsychic conflict. The frustration is imposed as an environmental press upon the personality. Since we are not dealing with an endopsychic conflict, we would not expect the aggressive defense reactions that we would find in the neurotic. Rapaport⁴⁸ raises the same basic objection to generalizing from most frustration experiments to clinical problems.

The problem of aggression has been of considerable importance in understanding interracial relations.⁴⁵ Gordon⁵⁰ has suggested that aggressive attitudes are more pronounced in the members of the minority group who have suffered frustrating discrimination. Allport⁵¹ has described the role of aggression in "scapegoating." A study of Ackerman and Jahoda⁵² reveals their findings on the dynamics of anti-Semitic attitudes. They report that all of their cases (collected from 30 psychoanalysts) had diffuse anxiety and lacked security socially, economically, and emotionally in their relations to the members of their group. They suggest that the anti-racial feelings were a defense against self hate. Since the patient cannot resolve his inner conflicts, he retreats into a pre-occupation with external events. They suggest that in this reaction there is a denial of the subject's own anxiety and a substitution of aggression. The subject then seeks more closely to identify himself with a dominant group. There is an accompanying development of reaction formations and compensatory emotional drives. The conflict results further in a rejection of parts of the

subjects, image of himself and a projection of such material.

Thus far we have attempted to describe the determinants of aggressive behavior, attempting to stress that it is not to be reified, but regarded rather as a type of response. We have further suggested that we should be particularly concerned with that behavior in which the individual is oriented toward his own goals without full regard for the goals of others. We recognize that society may or may not approve of such behavior. We have found that there are constitutional factors determining the presence of aggressive behavior. We have also seen that there are stages in the development of aggressive behavior that are rather commonly experienced by the members of any given cultural pattern. In our own culture pattern, we have stressed the role of the child in relation to his parents. Important difficulties arise as a consequence of his dual relation of loving them and yet rebelling against them because of the frustrations they present. We have seen the importance of the strength of his love toward his parents and the importance of the relation of the standards they set to the standards of the community. We have seen that the amount of aggression displayed tends to increase with increasing social contacts, although it will become less overt and more in socially approved forms as the child grows older. In the adult we find a continuation of the socialization of aggression, with its appearance being frequently masqueraded by social forms. Our problem now is to apply this knowledge to the more striking deviations that call themselves to the attention of the clinician, to understand why too much aggression may be present, or conversely why there may seem to be an absence of aggression.

V. Both Endopsychic and Environmental Conflict

A. The Child in the Clinic

As soon as we begin to consider our clinical data we are faced with a problem that should be frankly recognized but not over-

emphasized. The explanatory principles that we develop are designed to permit us more adequately to grasp the problems we see. In some clinical material it is possible to recognize that the individual is attempting to meet the demands of an environment that seems hostile, and we can recognize rather readily the conflicting forces which are still present. In such situations the clinician responds by helping the individual to understand the press of the environment and the conflict is conceived as an expression of a response to these presses. There is, however, another group of material in which the present problem is not to be explained merely in terms of present environmental press. Here we think primarily in terms of a crippling weakness of the personality structure which becomes manifest in a distortion of the individual's interpretation of the meaning of the environmental press, which is conceived as related to his inner life rather than as simply external forces. It is to be stressed that both types of approach are concerned with the dynamical pattern underlying the present behavior difficulty but that they are dealing with different levels of problems, levels which tend to blend into each other in some cases. Our problem then is not to choose between an analytic and a non-analytic approach but rather to recognize that each approach can fruitfully be utilized in handling the problems appropriate to it. The distinction is not on the basis of the severity of the maladjustment but rather on the relative importance of present environmental stresses as compared to residuals of earlier unsolved conflicts.⁵³

The dichotomy becomes apparent as soon as we examine our clinical material as seen in children as well as in adults. Thus, Klein⁵⁴ and Levy⁵⁵ with their psychoanalytic orientation would see in such behavior as the unruly aggression shown by children while being bathed or having their hair washed an expression of castration anxiety. They would feel that this was the typical response of the child in our culture when he becomes aware of the

primary differences in sex anatomy. However, Conn,⁵⁶ on the basis of a study of 200 children with a play interview technique, reports that while some children are disturbed, a large majority of boys and girls respond to the first sight of genital differences without upset or disturbance. The aggression that may be shown against a younger sibling may reflect the guilt associated with an unresolved Oedipal conflict, or it may be more directly related to the press coming from the newly-introduced restrictions on the older child's behavior. The determination of the basis of the conflict requires an investigation of the interpretation the child has used (consciously or unconsciously). The clinician may find identical means of solving the conflict, however, on the basis of either assumption.

One of the most common problems encountered in clinics working with children is the fear reaction, as is suggested by the study of Foster and Anderson.⁵⁷ Here one is more apt to find an avoidance of aggression although there are cases in whom there is a display of extremely aggressive behavior as a defense against revealing the fear mechanism.

Anger reactions are frequently encountered especially with younger children. In most cases these are apparently rather direct manifestations of aggression toward the frustrating situation and are to be thought of as normal (although probably many of them could be avoided). On occasion the behavior becomes more complicated, and the anger is not merely against the immediate frustration but against the present frustration as a symbol of other, earlier frustrations, and we have the temper tantrum. Anger has long been mentioned⁵⁸ as an important part of jealousy, and it frequently is manifested by open aggression. The aggression may be directed against the rival, against the person whose affection is desired, or against the person himself.⁵⁹ The problem is thus one of direct expression of the aggression or of handling it through one of the defense mechanisms we have already dis-

cussed. Frequently the directing of aggression toward the person whose approval is sought results in an ambivalent reaction, since the parent may thus be loved and hated. Peller⁶⁰ suggests that this ambivalence is more acute with children than with adults, and stresses the desirability of resolving the conflict.

It would be expected that where the conflict is not solved, the child would be unable to face his own aggression and would lack security. It is felt that the study of Prichard and Ojemann⁶¹ would suggest this behavior actually is present in many "insecure" children, although they were not primarily concerned with the underlying motives. Rogers⁶² in commenting upon foster home placement, stresses the need of security for successful placement of children and points out that a child forced into an undesired foster-home may be expected to show strong tendency to return to his own home. He may be expected thus to direct aggression against the foster home even though it may be objectively more desirable than his own home.

When we turn to the area of juvenile delinquency we again find a variety of patterns of aggressive behavior. Aichorn⁶³ suggests that delinquency may be regarded as one expression of rebellion against the restrictions that our culture places upon the expressions of instinctive impulses. Gleuck⁶⁴ emphasizes the importance of the nature of the identification the child makes with the mother and father. A psychoanalytical orientation toward our problem would cause us to look for abnormal expressions of aggression when we have a persistence of the habits of an earlier stage of development into a latter stage or when we have a regression to an earlier stage. Whether we would have greater or less aggression would depend upon the interplay of pressures affecting the individual. Thus, it is possible for the aggressive delinquent and the withdrawn child to show many similarities of adjustment. Blanchard⁶⁵ reports cases demonstrating the role that emotional deprivations, repressions and conflicts play in educing

enuresis, soiling, excessive masturbation, and other continued sex play. Chadwick⁶⁶ concludes that frustrations and repressions form the roots of neurotic symptoms at all ages but stresses the relatively greater role of present frustrations in the child as compared to the emphasis upon remembered frustration in the adult.

A primary orientation in our review has been the advantage of looking for the underlying pattern of conflicts that produces the symptomatic behavior. Thus, we find that Isaacs⁶⁷ has recognized that one reaction to fear and anxiety may be aggression, and Pearson⁶⁸ recognized the role of anxiety and guilt feelings derived from psychosexual conflict in determining patterns of delinquency. Blanchard⁶⁵ states that she has found the same relation of anxiety and aggression in cases she has carried for treatment. She finds that within the limits set by the treatment situation the children show intense ambivalence, with a decrease in aggression as the conflicts became resolved. It is perhaps in order to belabor our point. We are not trying to establish a new "theory of delinquency"; we are not even trying to say all conflicts involve aggression. Rather we are attempting to show that aggression may be expected to occur in many conflict situations as an expression of the conflict and as an attempt, frequently unsuccessful, to resolve the conflict situation. Whether the behavior will stress aggression, stress the avoidance of aggression, or take some other form is apparently more a matter of the structure of the psychological field in which the conflict occurs than it is a matter of the existence of conflict.

The aggressive reaction may be widespread as in the cases we have cited thus far or it may be confined to a narrower field of behavior. Buxbaum⁶⁹ has suggested that if strict prohibitions are raised about an activity at the time that the child is practicing the mastery of that activity one may expect his development to be fixated at the stage at which the disturbance occurs and to be expressed by the hostility that that particular phase of development

puts at his disposal. She cites as an example a case of stuttering in a two-year-old boy whose mother had made a major issue of his using a forbidden word. When the prohibition was removed, the child made intensive use of the word for a period and then lost interest in it. The stammering also disappeared. She suggests that interference with other vital activities such as eating, sleeping, and daily routines such as washing and dressing, may be expected to have similar results. She further suggests that if such a conflict is not resolved a future neurosis may easily make use of these points of fixation. Blanchard⁶⁵ reports finding several cases in which speech development is apparently normal up to the age of 18 months or two years when its development is suddenly interrupted, with the vocabulary either arrested or lost. She states that the histories furnished by the parents suggested solicitous care with little opportunity for the exertion of efforts to satisfy wants, sometimes with nursing or bottle-feeding to a comparatively late age. In other instances, habit training and play activities had been closely supervised and the child had been subjected to an extremely repressive discipline. In each case then, self-assertion was forced into negative channels. She reports that they responded quickly to freedom in play activities and to stimulation of interest and effort. We would expect similar difficulties to occur with other skills and with school subjects. The difficulty may be generalized as a possible aggressive reaction against authority figures, or it may be localized to a single area as an expression of a conflict developing, in Buxbaum's terminology, at the "practicing stage" for the new skill.

B. The Adult in the Clinic

We turn then to the survey of the adult in the clinic on the same theme with which we started our survey of the child in the clinic. We need to recognize the presence of both environmental press conflicts on the one hand and endopsychic conflicts on the

other. We would expect that the difficulties of adjustment of the adult would normally center about the endopsychic conflict to a larger degree than did those of the child both because of his greater ability to cope with his environment and because of the increased perspective that he has acquired during the years.

Just as children may show different overt behavior in response to inner conflicts so the adult reactions depend not merely upon environmental and endopsychic press but also upon the behavior field in which these occur. Abrahamsen,⁷⁰ in writing on mind in relation to crime, has stated that while aggressiveness hides inner weakness there may yet be a resulting insecurity and feeling of inferiority. Such emotional factors combined with the aim of some gain may instigate criminal behavior. He would distinguish between the "momentary offenders" who he feels are not to be considered as essentially criminals and the chronic offenders. In the latter group we may consider those who are compensating for some physical defect, a reaction analogous to other psychosomatic reactions we will review in the next section. Here the aggression is directed outwardly against society, resulting in the socially-unacceptable criminal behavior. As a special group, Abrahamsen cites the surprisingly large numbers of first offenders who are forty or fifty years of age and suggests their aggression against society is frequently related to the physiological changes taking place then. Here, too, he would consider those showing schizoid personalities. A second group of chronic offenders in whom Abrahamsen feels aggression is present he characterizes as the neurotic and compulsory offenders. Thus, he states that in the pyromaniac or kleptomaniac one may say that unconsciously the desires of the id and the desire for punishment alternate and the obsessional neurosis acts as a defense against the aggressive impulses. The conflict is internalized while the person's super-ego keeps the conflict back with the result that he has to act out his inclinations. Abrahamsen would feel that deep in the unconscious

is a wish, such as a sexual one. Still another group he designates as offenders with neurotic characters, a group frequently described as psychopathic personalities. He feels that a distinct trait in their conduct is aggression, which is for them a form of a chronic self-destruction. The chronic alcoholic and the Don Juan would be analogous types. Abrahamsen suggests that there is not only this active neurotic type but that there is a passive neurotic character, showing passive and dependent traits which he tries to deny in aggressive behavior. Finally, he suggests a group of offenders with faulty development of the super-ego. These people are described as having an ingrained hatred against authority and society, their criminal activities being approved by their ego and super-ego. We would expect their aggression to be rather directly against situations they found frustrating. In speaking of the murderer as a special problem, he expects to find its psychological roots in the person's aggressions related to attack and defense. Abrahamsen would distinguish between the symptomatic murder, where the aggression comes from distorted erotic drives, and murder due to aggressive drives. Here he includes alcoholic murder, substitute murder, and murder due to physical inferiority. We should not leave the impression that all criminals show neurotic or psychopathic personalities, however. Thus, Lowery states that only a fifth to a third of the cases of delinquency fall into one of the personality disorders of the most marked type (psychoses, mental defect, neuroses, epilepsy, and psychopathic personality). Lowery⁷¹ suggests as fundamental mechanisms first individual differences and the conflict over them. Here the aggressive behavior expresses the conflict felt as a result of seeing himself as different and frequently, although not necessarily, serves as a compensatory mechanism. A second mechanism is that of identification with a delinquent group, where the aggression against society is an expression of conformity with the mores of the local group. A third area from which Lowery

finds delinquent behavior issuing is the family situation. Here the aggression may be a defense against being overwhelmed by the parent or by siblings, or it may be a defense against the rejection by them. Lowery finds the role of hostile aggression so important that he designates aggression, hostility and frustration as a separate fundamental mechanism in causation of crime, although he recognizes its relation to his other mechanisms. Other fundamental mechanisms he feels are conflicts developing out of the psychosexual development and general personality characteristics.

Many of our bodily ills are most properly understood as psychosomatic.⁷² While their development reflects somewhat different conflicts in different individuals, there is a large area of agreement in their patterns of conflict. Thus, Saul,⁷³ in summarizing studies on essential hypertension, states that the literature shows general agreement upon the importance of emotional factors and the importance of hostile resentful feelings, and cites a study of Wolfe showing that the dreams of hypertensives show aggressive impulses. Apparently the problem is closely related to the direction of the aggression. If it can be directed outwardly, we do not expect the development of hypertension. If it is inhibited so that the person appears to be non-hostile or even gentle in spite of his intense and chronic hostility, then there is considerable possibility of the development of essential hypertension. Dunbar⁴⁵ finds the patients with coronary disease and pseudo-angina to present a very similar picture. Here, too, we find marked evidence of repressed hostility, usually with a sense of guilt and a tendency toward self-punishment. Important apparently in the development of psychosomatic cardiovascular involvements is the presence of aggressive, hostile competitive impulses which are mobilized and near to consciousness but repressed. It has been suggested that asthma may be considered as a defense against aggression. The typical structure indicated is a

strong dependency relation with the mother-figure. This relationship is threatened by the temptation to behave in such a manner as to estrange the mother-figure, and the asthma serves then as a defense against this aggressive tendency. The presence of unaccepted aggression in endocrine disturbances, in psychogenic epilepsy, and in headaches has frequently been reported. As has been indicated, it is important whether or not the individual can give expression to his aggression or whether he must use a defense mechanism so that he can deny to himself the presence of the aggression. There is a rather general acceptance of the psychogenic origin of much enuresis. It has been suggested that it may represent aggression against the parent, in the case of children,⁶⁹ or it may serve as an unconscious aggressive defense against sexual wishes in the adult. In similar fashion, psychogenic diarrhea may be considered as an expression of aggression whose expression is inhibited and another activity substituted. If a different defense mechanism is used, we have the appearance of constipation, again as a defense against the unaccepted aggression.⁷³

When we turn to the neurotic personality structure, we find that the problem of how to handle aggression is a source of much difficulty. As Horney⁷⁴ has suggested, there may be a propensity to be overaggressive, frequently with no awareness of it, or there may be a surface attitude of submission, again usually without recognition of the role being played. In the latter case, the behavior and response to conflict reveal the presence of rather strong aggression that is not accepted. Thus, when we look below the surface of an unjustified worry about the well-being of another person, we typically find that the person who is felt to need protection is actually a hated person and that the over-concern is really a protection against our own aggression. When the reaction becomes very marked, the conflict is not handled on the basis of the present problem, but there is a regression to child-

hood; that is, the unsolved conflicts of that period become symbolically involved, and the present problem comes to have a new, unbearable meaning to the patient. The more completely this symbolic regression occurs, the more necessary it is for the individual to deny his aggressive behavior. Fenichel⁸ suggests that the regression in anxiety hysteria in general is a limited one since the main temptation which has to be warded off is represented by the wishes of the genital Oedipus complex. A very considerable role is played by hostile aggression in suicide and morbid fear of death.⁸ The development of a phobia does not always successfully contain the aggression. Where the attempt to thus project the aggression fails, the phobia may be expected to expand progressively.

Like the hysteric, the homosexual has difficulty in handling his aggression. It has been suggested⁸ that in the personality structure of the homosexual, there is to be found unconscious hostility toward the father. The aggression is reflected in the ambivalence of the homosexual love. The act not only relieves an early fear of the father, but also serves to deprive him of his power. In a similar fashion, it is possible for a female homosexual to symbolically express her aggression against her father by her homosexuality. In the case of exhibitionism, the primary aggressive behavior toward the opposite sex is not acceptable (castration fear), and the symbolic aggression serves as a reassurance against the anxiety insofar as it gives reassurance of the presence of the penis. It has been suggested that the structure of the aggression in the female exhibitionist is more complicated, serving either to make the male admire and depend upon what they formerly despised, or the unconscious attitude of threatening the male with castration. In each of the sexual problems we have considered, we find support for Horney's observation that the neurotic structure is characterized by difficulty in displaying appropriate aggression. The aggression is determined by the conflict present in

the individual rather than by the environmental situation. It may occur with undue overt aggression as in rape or it may be suppressed as in the person who attempts to deny his sexuality. We would expect the difficulty in controlling the aggressive behavior to continue as long as the conflict remains active. Thus, the exhibitionist who cannot fully accept heterosexuality because of its threat to him cannot be content with his displaced aggression since it confirms the existence of the threat. Fenichel⁸ suggests that the same difficulty in control is present in the impulse neuroses. Their impulsive acts serve the purpose of escaping from a danger. The defensive aspect of the pathological impulse, however, does not prevent it from bringing a distorted satisfaction of sexuality or aggression. There is then a condensation of the desire for security on the one hand and the basic urges on the other. In terms of expression of aggression, the impulsive neurotic, having denied his aggression, may now express it. If his denial is accepted, the utilization of a symbolic expression of his aggression may permit a solution to his conflict, at least until it is reactivated.

It is not only in the neurotic personality that we find difficulty in handling aggression. In the depression the aggression that has been directed toward the frustrating world about the patient is now directed against the patient's own ego. In the classical depression, the unacceptable aggression becomes self-hate, the aggression has been internalized. One must not lose sight of the original conflict, the desire for greater self-esteem, the desire to be given more love, since it is this conflict which precipitates the aggressive behavior that must be denied by introjection. We can understand better the aggression the depressed apparently directs against himself if we ask not why should he hate himself, but rather why should he feel that he is hated so.

It is suggested that this mechanism is essential to both the neurotic and the psychotic depression. How, then, are we to re-

gard the handling of aggression in the mania? It is suggested that the patient's aggression is still present but that here he is using the defense mechanism of denial through over-compensation. The defense structure is frequently not simple. Thus, there may be the projection on the basis that the patient loves himself and that he feels everybody else must feel the same way about him, or there may be a rationalization of the mania on the basis of its fulfilling some ideal purpose.

There is much evidence of disordered handling of aggression in the schizophrenic. His reactions may vary from an attempt to deny aggression, in hebephrenia, to a marked display of aggression in the negativism of the catatonic. The outward manifestation of aggression in the individual patient, however, will vary markedly from time to time. In the schizophrenic, as in most other psychotic reactions, we find the aggression which has become directed inwardly is quite marked and offers a real problem in the care of the patient. As Menninger⁹ has stated, attempts at self-mutilation are not an infrequent phenomenon. From the viewpoint of treatment, this inward direction of the aggression makes for precarious therapeutic relations because of the ambivalence with which the patient accepts such a relationship.

VI. Therapy

Thus far we have been concerned with the development of aggressive behavior in the individual and the ways in which it becomes manifested when the individual is not able to accept it. We are now ready to consider what procedures may be used to assist the individual.

A. Level of Treatment

A first issue must be the question of the level at which we plan to meet the problem of the displaced aggression. It is possible to give essentially supportive therapy. Here one is concerned with

alleviating the conflict sufficiently to permit the individual to cope satisfyingly with the present environmental pressures, but one is not directly concerned with attempting to resolve conflicts deeper in the personality structure which may have rendered the individual sensitive to those environmental pressures. Under certain circumstances such therapy is definitely indicated. Blanchard⁶⁵ has pointed out that in certain problems it is of more value to accept the child on his own terms without attempting to make him conscious of the mechanisms that may lie behind his present behavior; particularly is this true if the therapeutic contact with the child is not expected to be of sufficient duration to fully work out the basic conflictual material. Sullivan⁷⁵ is equally conscious of this time factor in dealing with adults. He makes the further issue that the defense mechanisms have served as a defense structure and frequently the existing conflict is less disabling than the consequences of its removal. This would be a particularly important factor in older people who have committed themselves to their personality structure in many ways: through marriage, through occupational choices, through friendships, and other interpersonal relations. In discussing the indications and contraindications for analytic treatment, Fenichel⁸ points out several limiting factors. Neither the very young nor the very old are suitable. Actual feeble-mindedness is another contraindication, although apparent feeble-mindedness may be an expression of the conflict within the individual. Certain life situations act as contraindicators. In general, when treatment would elicit aspirations that are impossible to fulfill, it is perhaps wiser to leave the defense structure undisturbed unless it is very disabling to the individual. One should consider carefully the importance of the conflict area and the urgency with which treatment is indicated. There is little merit in probing the personality to remove minor conflicts, and Fenichel feels that the psychoanalytic method is not adapted to cases in which immediate improvement is urgent. He

suggests a preliminary non-analytic exploration to evaluate the cooperativeness of the ego. He suggests that a major difficulty is present when the aggression becomes manifest in severe disturbance of speech, since the analytic method depends upon talking.

1. Accepting the Punishment

There are, then, many situations where the clinician will not attempt to probe deeply into the personality structure in his treatment. (He may have explored into the unconscious materials in the diagnostic procedure which lead to this decision, however.) Lewin's⁷⁶ analysis of the punishment situation is useful in suggesting means of approach to the problem. It is possible to make the task acceptable to the individual, and by thus changing its value to him, resolve the frustration. The present problem is seen not as a symbolic resurrection of some earlier, unsolved problem, but as a simple problem encountered today. It may be possible to make the punishment acceptable. Frequently, the aggression rejected by the individual is not abhorrent to the society in which he lives. We can accept the abstract concept that all children become angry at their fathers at times, although the individual may feel that it is not acceptable that he should be angry at his father until he is able to see that his reaction is only a specific example of the general statement.

2. Removing the Barrier

The next possibility is that of attacking the barrier. Sometimes it is possible to remove the barrier. Thus, in working with children, the parent may come to see his role in eliciting the aggression and be able to remove the frustrating factors. In many restraining situations, several of these approaches are made simultaneously. Page⁷⁷ has reported that her non-ascendant children became more ascendant as a result of training which was aimed at increasing self-confidence and found some indication

that the adjustment showed transfer to free play situations. Jack⁷⁸ had previously reported analogous findings, while more recently Lowenstein and Svendsen⁷⁹ have reported that children showing notable symptoms of shyness showed improved interpersonal relations while together in a summer camp. For most of the children, the improvement continued after they left camp. Halliburton⁸⁰ has suggested the possibility of resolving aggressive impulses in defective delinquents through a game situation providing both creative and destructive experiences. Solomon⁸¹ has called attention to the role of proper occupational choice in helping to resolve aggression. In similar fashion, he finds that hobbies serve to meet the needs of the individual for a means of expressing powerful, inward drives that are not satisfied in his other activities. Weiss and English⁷² stress the need for treating displays of aggression in terms of their meaning to the patient, stressing that the patient needs not only to be understood, but also to receive adequate emotional support. In discussing the use of terrorism, placebos, rest, and suggestion in their various forms, they recognize their effectiveness in relieving the conflicts in certain cases, but stress that the basic conflict still remains, rendering quite possible future maladjustment.

Lewin's barrier can be attacked in still another way. He states that the outer barriers are essentially social in nature and that in the child, of whom he writes, they represent the power of the adult. We may not only face the immediately present barrier, but we may attempt to attack the symbolically present barrier as well. Here we are working with aggressions which are manifestations of endopsychic conflicts. Fenichel⁸ has stressed the advantages of the psychoanalytic method in working with such conflicts. It is especially adapted to the neurotic structures although work has been reported on analytic therapy with the schizophrenic psychotic. Klein⁵⁴ feels the need of having the child reproduce the memories of sexual experiences and phantasies with interpreta-

tions of the material by the analyst, but Seeberg⁸² reports that overt, aggressive behavior in the child can be corrected without its repetitious release to the therapist if favorable relationship is formed between patient and therapist.

B. Group Therapy

It is difficult to place group therapy in our series since the level at which it operates varies both with the therapist and with the patient. While Schilder⁸³ felt that the effectiveness of the group therapy lay in helping the patient to work through his basic conflicts, Thomas⁸⁴ concludes that the "repressive inspirational" method is much more frequently used. Paster⁸⁵ has suggested the effectiveness of the group therapy lies in the creation of an informal, sympathetic atmosphere which permits a closer relation between the therapist and the patient. The permissive atmosphere lessens the resistance of the patients to discussing their conflicts and enables them to release their hostilities. Their guilt is lessened, they are able to gain greater insight into their own problems, and resocialization is promoted with identification with the group.

Ackerman^{86 87} agrees that the group affords an opportunity to imitate the aggression of the others, to receive emotional support, and to lessen feelings of guilt and anxiety. He feels that it permits the patient to act out his conflicts rather than merely to think them out. As the concept of the self is modified there is increased self-confidence and tolerance. He questions, however, whether all forms of resistance to expressing repressed material such as would underlie abnormal aggression will respond equally well to activity group therapy.

Most therapies, whether group or not, involve vocalization about the areas of conflict, and Sullivan⁷⁵ has suggested that in adolescents and adults this is usually, if not always, necessary for permanent results. However, the work of Levy⁷⁸ and Mo-

reno⁷⁹ may be cited as examples of techniques where the patient acts out his conflicts without necessarily verbalizing about them.

Slavson^{90 91} finds that the withdrawn person responds better to group therapy than the hyperactive and suggests that those who are extremely aggressive are not as accessible for treatment by this approach. Crider,⁹² however, feels that patients who project their aggression respond better to a non-directive type of therapy than do those who repress their aggression. The work of Aichorn⁶³ would suggest that if the structure of the group therapy is changed aggressive individuals may show a marked improvement.

C. Patients, Not Symptoms

The need of understanding the dynamics lying behind the aggressive behavior has been stressed by Wolberg.⁹³ He suggests that at least four groupings must be considered. His direct aggression group is characterized by limited ability to tolerate frustration and by no fear of or respect for authority. He feels that for these people the use of a permissive attitude may actually be harmful, since the individual sees no reason to change. He has found it frequently desirable to let the child prescribe his own standards of discipline within rather wide limits. Once standards are set, however, there should be careful adherence to them. The child is accepted, but accepted within the determined limits. A second group he characterizes as power-striving, suggesting that here the conflict is with a super-ego structure so strong and cruel that the child does not dare yield to it and displays aggression as a means of self-protection. With this group he feels that it is important to use a highly permissive attitude and to expect an initial increase in aggression while they are testing out the limits of the permissive attitude. A third group is characterized by the children who are extremely dependent and submissive but whose basic aggressive orientation is shown

by their rages when they cannot get all that they expect. He feels that for them the denial symbolizes the crushing of their independence and their submission is concealed aggression. He would meet such a problem through a continued but graded increase in responsibility. Finally, he speaks of the shy and detached children who defend themselves by submitting or withdrawing who have, however, underlying aggression. Here the initial approach is to support the child's self esteem.

Anderson⁹⁴ has commented upon the values of non-directive therapy counseling as diminishing the aggression present in the patient, while Thorne⁹⁵ has suggested that directive therapy may be helpful to an aggressive individual, citing among other procedures the deliberate induction of conflict which the individual can handle and which will clarify inconsistencies in his behavior.

We find apparent agreement between Sullivan⁷⁵ and Snyder⁹⁶ that treatment by occasional conference is not the most satisfactory procedure. Common to all forms of therapy we find an attempt to determine the source of the displacement of the aggression, an attempt to evaluate the individual's ability to understand the significance of his displacement, and an attempt to help him more satisfactorily to solve his conflict either through resolving it or by helping him to make use of a defense structure that can contain the aggression without involving wide areas of personality.

VII. Summary

In our survey of aggression we have seen that it may be expressed directly and overtly, or it may be disguised in apparently non-aggressive behavior. To understand behavior we must be alert not merely to its form, but also to its meaning to the individual. When we are faced with the investigation of some defense mechanisms, the important question is not what defense mechanism is being used but rather why must a defense mecha-

nism be used, what is it that the individual is defending himself against? We have used as the central theme of our discussion the aggressive forms because they are widespread and important in our life. All of us display aggression and fail to recognize that we display a great deal more than we suspect. It becomes a major concern because it affects our attitudes toward the world about us and the people in that world, and perhaps as serious, it affects our attitudes toward ourselves, as psychosomatic medicine has so clearly shown. We may assume the existence of aggression in all people in our culture, and we should be ready to accept our own aggressions when they are appropriate and to look into their meaning when they are too strong or too weak. Indeed, it is questionable that aggression can be too weak; rather, it may be directed inwardly because we feel guilt in accepting it.

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Chapter VI

WITHDRAWAL FORMS OF THE DEFENCE MECHANISM

By EMILY L. STOGDILL, Ph.D., Psychologist
Ohio State University, Columbus, Ohio

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ERNEST L. STEIN, Ph.D., Psychologist

Ohio State University, Columbus, Ohio

Chapter VI

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Ohio State University, Columbus, Ohio

I. Introduction:

A. Retreat Motivated by Inadequacy Is a Withdrawal

When the withdrawal behavior of an individual in a conflict situation is motivated by his fear of being found inadequate rather than by the harmful character of the stimulus, the resulting behavior constitutes a defense against a feeling of inadequacy and so a withdrawal form of the defense mechanism. There are many forms of withdrawal which are quite obviously retreats. Some of these are negativism, seclusiveness, shyness, regression to earlier levels of behavior and refusal to pay attention to the environment or some aspects of it. Other forms may be quite difficult for the observer to refer to their immediate stimuli. These arise from a symbolic relation of the individual to his environment, or from one in which his reaction springs from private or less apparent clues. In this group are reactions such as neurotic blindness and deafness, slips of the tongue, the "nervous breakdown," attitudes of inferiority, and illnesses of psychosomatic nature, among others. The concept of the "defense mechanism" originated in the psychoanalytic system of S. Freud¹ and was developed further by his daughter Anna Freud² and others of his followers who considered all such mechanisms to be uncon-

scious attempts of the ego to defend itself against fear and anxiety. Recently Dollard, Doob, et al³ have used the term "substitute responses" and have distinguished them from rational problem solving behavior in which the individual makes a simple retreat from an unwelcome stimulus, as for example, a retreat to the indoors from out of a pouring rain. Maslow and Mittleman⁴ employ the term "coping mechanism" instead of "substitute response." Extreme forms of withdrawal are to be observed in the neuroses and psychoses. Behaviors such as catatonia, stupor, apparent mental deterioration, regression of adults to infantile dependency and similar types of isolation from interpersonal participation or response to the environment characterize the more pathological withdrawal responses to conflict situations.

B. Certain Dichotomies as Defense Mechanisms

It is a common observation that all animals, including man, move *toward* some sources of stimulation and *away from* others. It has been assumed that the motivation for this behavior is that the animal desires to get more of the stimulus toward which he moves, and less of the one from which he retreats; or that the former is pleasant, the latter unpleasant. The extremes of this withdrawal-approach continuum have been variously referred to as aggression-submission, aggression-withdrawal, extroversion-introversion, superiority-inferiority, participant-isolate, ascend-ance-submission, leader-follower, adience-abience, and the like. It is commonly accepted that if an individual desires something, he will go toward it, and that avoidance behavior indicates distaste or fear. More critical observation of behavior, however, has brought to attention certain responses which do not seem to fit into such dichotomies.

For example, acceptance or refusal of food by a child may not always be a measure of hunger, but may be a measure of other

needs such as avoidance of parental displeasure, or securing approval and affection. Failure to make grades in school may not be related to lack of ability or to a desire to escape from education, but may also be a means of protesting against over-dominant parents. Withdrawal from an activity may not mean that the activity itself is unpleasant, except for the meaning that it has acquired socially. Hysterical blindness may not mean that the individual finds the objects in his vicinity distasteful, but that his lack of sight frees him from certain responsibilities and permits him to engage in activities that he likes. Thus when approach-withdrawal behavior is considered in a wider frame of reference that includes more than the satisfaction of a single, isolated motive or drive, it becomes apparent that numerous interrelated, interpersonal and environmental forces combine to motivate behavior. It is also clear that certain stimuli and forms of response acquire a symbolic value which is understandable only through knowledge of the context in which it arose and the methods by which its significance is maintained. It is this complex and seemingly contradictory character of the withdrawal response that necessitates a more sophisticated explanation than that of a simple avoidance reaction to a harmful stimulus.

II. The Defense Mechanism

A. Freud's Idea of Defense Mechanisms

Freud¹ points out that the mechanisms employed in defense of the self, or ego, serve two general purposes: as substitute pleasures and as defense against anxiety. The withdrawal mechanisms fall in the latter category. Defenses against anxiety are not only self-deceptive, but are also intended to conceal one's feelings from others. They are face-saving devices and are not to be confused with fully or partly insightful, conscious behavior such as that of an individual who makes a deliberate intentional substitution. In contrast, the withdrawal mechanism serves to keep the

person unaware of the deep emotional aspect of some experience which was too painful to be faced in a direct manner. It is possible for one to remain unaware of need for self-defense.

The very existence of the defense mechanism depends on the ability of an individual successfully to keep apart two systems of motives. If he is only partly successful in doing this, breakdown may result. For example, many withdrawal patterns originate and are maintained by feelings of love and hate toward the same individual, usually toward one upon whom the withdrawn person is very dependent. For example, one adult unmarried woman in conflict with her overdominant mother developed such regressive attitudes that in the mental hospital in which she was a patient she occupied herself with doll play, and talked baby talk. Regression in this case served to reassure the patient that she was too young to harm her mother. In this way she was able partly to control her aggressive negative feelings, but the effort required so much time and energy that she had little left to use in other activities, even those in the hospital ward. Although it may require long practice to perfect highly organized forms of evasion such as this, the person may fail to realize that he is enmeshed in such habitual reactions until he is almost powerless to control them. By this time he may have become so adept at hiding his true feelings from himself that his attention is largely focused on maintaining his symptoms, or his defense mechanisms, rather than on solving his problems.

The self-deceptive character of the defense mechanism frequently makes it difficult for students of human behavior to understand and deal with withdrawal reactions. As long as the investigator's attention remains directed toward the symptoms and toward what the person who exhibits them says they signify, he may find it difficult if not impossible to understand the real meaning of the behavior.

Freud¹ found that many of his patients who complained of

functional symptoms such as deafness, inability to leave their homes, forgetting engagements and the like, were protecting themselves by these withdrawal attitudes from anxieties arising out of fears of inadequacy or other real or anticipated distress. Often the process of becoming aware of anxieties of such severity causes intense suffering. Since it is this pain which the patient's whole energy is devoted to avoiding, he may feel entirely unable to face his conflicts without the help of someone upon whose insight and emotional support he feels safe in relying. One function of the therapist is to supply such support and to help bring underlying fears to light and dissipate them by analysis. Freud observed that by these means symptoms frequently disappeared. The functionally deaf person could then hear; the restricted patient could go about freely to attend to his affairs; the forgetful person could remember; the shy patient was no longer oppressed by timidity. In his "Psychopathology of Everyday Life," Freud⁵ describes many similar retreats to safety observed in otherwise normal individuals. The fact that, by psychoanalysis, Freud was able to help some of his patients eliminate their fears and consequent withdrawing behavior marks an important advance in the history of therapy.

B. Disguised Forms of Withdrawal Mechanisms

In general we can say that when an individual is put in a situation in which he is penalized as much (or more) for attempting to withdraw as he would be for the type of response he fears to exhibit, he may develop forms of disguised withdrawal behavior. From psychological and psychiatric literature it is possible to collect an extensive list of such forms of behavior. For example, leaving a task partly completed may easily be recognized as expressing a need for withdrawal, but it is not so obvious that blind persistence in a task which has ceased to be meaningful may also be the result of a continuing need to with-

draw. Setting up perfectionistic goals, meticulous performance of the easy or pleasant part of an assignment, delaying the performance of a task, overdependence on another person, and being "too busy" with other activities, may all be disguised forms of avoidance behavior. Thus it is evident that some of the most significant forms of withdrawal may not appear to be withdrawals at all. It is difficult to detect whether a particular behavior is due to a pathological attitude. Any particular instance must be considered in a context of the usual behavior of the individual and of his group before we can classify it with any assurance. The central factor in the behavior of the withdrawing individual is his need to escape from being placed in a situation in which he fears that he will be inadequate.

III. Other Forms of Withdrawal Mechanisms

A. Jung's Classification

Jung⁶ employed the terms introversion and extroversion to describe the behavior characteristic of individuals who typically exhibit withdrawal or approach behavior. Introversion, for Jung, is "a turning inward of the libido," or psychic energy. In many respects the behavior he describes as characteristic of introversion is similar to the withdrawal form of adjustment in that the individual turns away from the environment and solves his problem inwardly rather than by an attack on the environment. Introversion, however, is not thought of as being a form of abnormality. Jung's early classification of all behavior into introvert and extrovert soon proved inadequate to describe the individual whose behavior varies from one situation to another, and who does not show a predominant trend in one direction as is indicated in the definition of the two terms. To denote the person who did not fit in either of these two categories, the term "ambivert" was selected. Later studies still further structured the

field of human behavior with respect to the direction of the response tendencies and revealed the impossibility of adhering too strictly to this particular typology.

B. Murphy's Emphasis on the Meaning of an Act

The genetic approach to the study of personality further emphasized the widely different origins of introvert behavior in various individuals, or in the same individual in different situations. Murphy⁷ for example, points out that there are types of behavior which appear about the same in respect to withdrawal, but which arise from quite different causal situations, and for these he suggests the terms "willing and unwilling introversion." He feels that we should look at the meaning of an act rather than merely at the act itself. The creative, imaginative individual who is sufficiently occupied with the interesting products of his own thought life may be quite a different person from the one who, retreating from social contacts which he fears, seeks safety in inactivity or inconspicuousness. Rorshach⁸ has called introversive a person whose score on the Rorshach test shows "rich inner response but little affective response to the outer world." The term "narcissistic" has also been employed to describe an attitude strongly directed toward the self, literally a self-love. Many of the earlier names applied to behavior closely related to the withdrawing form of the defense mechanism were used to differentiate various kinds of observed behavior and not so much for the purpose of explaining it.

Another form of withdrawal behavior is described by the term "inferiority complex." All forms of the inferiority complex, severe or mild, should be considered as forms of withdrawal behavior. The true inferiority complex is a highly emotionalized and abnormal attitude in an individual which involves his participation in activities as well as his interpersonal relationships. This attitude does not arise essentially from incapacity but rather

from a fear of loss of status. Under pressure, persons with extreme fears of this sort may become highly resistant and withdrawing even to the extent of mutism or immobilization, in extreme instances. But as the term "inferiority complex" is commonly used, without the strictly abnormal context of the technical psychiatric vocabulary, it still pictures a form of neurotic withdrawal behavior. In this common usage it is implied that its possessor has little control over certain behaviors and attitudes and therefore should be excused for his lack of participation in social events in the same sense that a physical disability would excuse him from participating in athletics. In some circles, indeed, it is considered an indication of commendable modesty to "have an inferiority complex" and is accepted as a polite or even praiseworthy recognition of one's limitations. The fact that there is little correlation between such an attitude and the real ability of an individual shows this form of behavior to belong to the class of withdrawal behavior. The acceptance of the inferiority complex so readily and with such tolerance constitutes one of the neurotic influences of our times, according to Horney.^{9 10 11}

When reality seems so threatening to an individual, he may build up an inner dream world and a fictitious personality to suit his own needs. While he is preoccupied with this process, he may not literally be responding to the external environment in any sense that should be called withdrawal, any more than a man busied in building a house is referred to as withdrawn from other activities. It is true, however, that the original stimulus for the inner activity, for the daydreams and the phantasies, is a definite reaction to a world in which he felt insecure and threatened with loss of any prestige he might have enjoyed. Although we have been accustomed to think of emotional expressions as forms of social communication, the withdrawn person may employ them for a purpose related to his inner world, rather than to the people around him. Lacking a feeling of security in com-

municating with those about him, the withdrawn person may dramatize his feelings for himself, as though he were his own audience. Should this occur, it might be difficult for the observer to recognize that such emotional behavior was not intended for his benefit, but functioned, perhaps, as a form of self-distraction from more painful feelings, or as a release of tension without reference to any outer audience. Many forms of behavior described in words hyphenated with "self": self-centeredness, self-love, self-punitiveness may not in the least constitute attempts to gain the attention of other persons. Phobias, rituals, obsessions, fetichisms and infantile forms of regressive behavior may also be closely related to the inner world of the withdrawn patient.

Wolfe¹² has further pointed out that to "save face" is the chief function of the "nervous breakdown." The individual who is nervously ill has a "good excuse" for evading inconvenient demands without risking the disapproval that outright refusal might involve. Wolfe, also, considers that many withdrawal behaviors, less catastrophic than nervous collapse, are employed to ward off anxiety about situations in which an individual fears failure and loss of self esteem.

C. Morgan's Four Criteria of Unconscious Defense Mechanisms

Morgan¹³ points out that withdrawal may not merely be a negative state, but a tool for living, and that it may have its own inner organization and concerns. He suggests that the purpose of withdrawal for the patient is to escape the pain of the devaluation of his own ego picture, as well as to eliminate outside distractions so he may be free to develop his inner world according to his own needs. On the face of it, this does not sound potentially dangerous to mental health. The possible serious threat to good adjustment arises from three facts: (1) that the mere effort incident to withdrawal consumes so much energy fruitlessly, (2) that

withdrawal deprives the individual of experiences requisite for continued healthful mental and emotional development, and (3) that it deprives him of opportunity for self-correction in the light of objective reality.

Morgan further regards it as an impossibility to present a completely organized list of all forms of withdrawn behavior related to defense because their essential characteristic is that they do not follow a reasonable pattern. He feels that we are forced to conclude that withdrawal is an attitude or a use made of various forms of reaction, rather than a characteristic of any specific form of behavior. Therefore, conceivably, almost any form of behavior, even some that might superficially appear quite aggressive, might be employed as a retreat from reality. The best criteria as to whether given behaviors are pathological withdrawals seem to be: (a) the degree to which the person fails to show insight into his behavior, and (b) the constancy with which the type of behavior in question is employed as a means of evading conflicts.

It is difficult for a person to detect the use of withdrawal mechanisms in himself, because there is such a large unconscious element in the situation. Morgan¹³ has compiled four criteria that can be used to detect one's own tendency to exhibit behavior of the fundamental mechanism of which one is unconscious or only imperfectly aware. He points out that we cannot, of course, evaluate an attitude of which we are only partly conscious and suggests that we should observe our actions in order to be aware of the following attitudes:

"(1) Resistance to change. . . . Abnormal rigidity in the face of situations which should bring about changes indicates that the attitude is probably determined by subconscious elements.

"(2) Degree of emotional fervor in defending the attitude.

"(3) Sensitivity to agreement. . . . If an attitude is built solely of conscious factors . . . one is not likely to be sensitive about it no matter how much it may differ from that of others.

"(4) Urge to convert others. . . . In being intolerant of others we are really disclosing our intolerance of our own subconscious attitudes."

IV. Origin and Nature of Non-Pathological Withdrawal

That withdrawal behavior is a natural response of the organism to certain situations seems self-evident. A withdrawing response is considered pathological only when it becomes patterned or habituated so that it occurs in situations where it is not appropriate in kind or degree and where it is not necessary for individual safety or self-preservation.

A. Withdrawal Behavior in Animals

Withdrawal behavior, as we have pointed out, is observed in all animals from simple unicellular forms to man. Holt¹⁴ believes that approaching (adient) behavior is the first reaction of an untrained organism to a stimulus, but considers that withdrawal from harmful or unpleasant situations is learned quite early. He admits, however, that there is some evidence for specific avoidance although he prefers to think of it as learned by experience from the environment. He points out that in our common forms of speech we never use the word "responsive" to refer to avoidance behavior. Withdrawing behavior is not necessarily a maladjusted form of response, in fact it may be the only adequate response for the safety of the organism under certain circumstances.

The least complex form of avoidance behavior is the purely physical withdrawal of the animal organism, or some part of it, from the vicinity of noxious stimuli. The most complex forms

are the withdrawal types of defense mechanism exhibited in the neurotic and psychotic behavior of man. A well designed experiment by Brown¹⁵ shows quite clearly that an animal will exert more energy to escape shock than it will to secure food, and that in both cases, the nearer the stimulus, the stronger the response will be.

The feared object may be animate or inanimate. Yerkes and Yerkes¹⁶ report that younger chimpanzees avoid animate more than inanimate objects, but adult animals show themselves about equally reactive to both, with perhaps slightly less avoidance of the inanimate ones.

The Kellogs¹⁷ found that loss of support and being left alone were causes of early fears in the infant ape they studied. At a later age, abruptness of the occurrence of a number of stimuli called out the avoidance response. The sudden appearance of a strange person, for example, caused withdrawal from him toward the familiar person in the situation. This calls attention to the fact that fears in animals may arise not only from impersonal environmental sources, but also from interrelationships between animals and man.

Many of the higher animals learn to withdraw from the rages of older members of the flock or herd to which they belong. Carpenter¹⁸ reports frequent observations of the retreat of younger monkeys from older, stronger male members of the group which he studied from an observation station in their natural habitat.

Studies of experimentally induced neuroses in animals indicate, however, that it is possible to set up such strong conflicts in animals that they will exhibit many forms of reaction similar to the human neurosis and psychosis. Withdrawal behaviors such as catatonia and stupor have been elicited in many different experimental animals. For example, Pavlov¹⁹ worked with dogs as subjects, Maier²⁰ with rats, Liddell²¹ with pigs and sheep, and found it possible to induce various degrees of neurotic withdraw-

ing behavior in these animals. Not only have experimental neuroses been produced in animals, but methods of relieving them of these neurotic forms of response are being devised and evaluated under controlled conditions. Hilgard and Marquis²² have compiled an extensive summary of the conditioned reflex experiments in this field.

B. Cultural Factors Influencing Withdrawal Behavior in Humans

Situations in everyday life which elicit withdrawal reactions in human beings are more varied, as well as less controlled, than the experimental conditions to which animals are subjected in a laboratory. Because of man's greater ability to employ symbols, and because these symbols become so extensively elaborated, man is capable of experiencing disorganization more readily than the lower animals. Man learns to react to stimuli that are less and less closely related to the original experience, and that become so non-specific as to occur in many situations quite remote from the one in which they became significant to the individual. Thus man is confronted more frequently and in a wider variety of situations by the stimuli which he has come to associate with earlier, distress producing experience. If man were not able to make generalizations, his feelings of confusion and anxiety would not be aroused by circumstances so essentially different from the original traumatic one.

I. Studies of Personality Patterns

Concomitant with his capacity for responding to symbols is man's ability to delay responses, which may serve as a mechanism for maintaining tension or drive relative to situations which cannot provide immediate satisfactions to him. Social control is frequently maintained by using these two processes, i. e., sym-

bolization and ability to delay response. Anthropological investigations are showing with increasing clarity that the extent to which the members of a culture exhibit withdrawing forms of behavior is related to the pattern of mores and customs of the group. Mead²³ studied thirteen different primitive societies. When these were classified according to whether the predominant cultural pattern of the society was cooperative, competitive or individualistic, Mead found that the personality characteristics of the members of these societies differed markedly. In the competitive cultures, individual status and ego-satisfaction depend upon continued striving for possessions and wealth. In cooperative cultures, personal security comes through membership in closed groups by means of which an individual's status is defined. In such a group there is less occasion for the development of aggressive traits which are necessary for the achievement of status in a competitive society. Studies such as this indicate that general culture patterns are of significance in determining whether an aggressive or a more withdrawing type of personal behavior will be developed and what behaviors will be regarded as normal in a given society. Davis²⁴ in a sociological study of a small southern community discusses the adaptive social function of anxiety during adolescence in promoting successful attainment of social goals and school progress. When this anxiety passes a certain optimal point, as is frequently the case because of adult solicitude, he concludes that it can cause harm rather than furnish motivation for progress.

Not only is a feeling of anxiety employed by our culture as a means of instilling a desire for social conformity, but the conviction is fairly widespread that social order can be maintained only when persons in authority impose considerable restraint. Instead of suggesting desirable behavior to children and encouraging them to carry it out, adults frequently insist that children should "be seen and not heard." The tendency is to teach children habits

of unquestioning obedience rather than habits of understanding cooperation. It is not uncommon to find parents who pride themselves on using modern methods of child training, resorting to force as the court of last appeal. In consulting a child guidance clinic for help with a difficult child, parents often say, "I have tried everything I know to do. I have punished him until I am ashamed to whip him any more." Or the child may be told that his parents will not love him unless he is good, or that God does not love bad children, or, "You are not my child if you ever do a thing like that." Thus restraint by threat or punishment rather than development through self-discovery becomes the principle by which the child is expected to learn. In such an emotional climate the child learns to place a premium on withdrawal and avoidance.

Again, many children are taught not to seek praise nor "show off." Sometimes parents, out of fear that a child will develop an inordinate need for praise and an unpleasant vanity—attitudes frowned upon by the group—refrain from expressing satisfaction over his achievements and speak to him only of his failures or of behavior to be avoided. Thus negative goodness comes to be a positive virtue, and the amount of evil from which one refrains becomes a measure of his moral stature. This is evident, for example, when a speaker, describing a good man, says in effect, "He is a good man, he does not . . . (smoke, beat his wife, take advantage of his position and the like.)" Or when students in a class in elementary psychology are asked to list their habits, their papers are likely to begin with: "I have no really bad habits. Of course, I sometimes—(smoke, have a glass of beer, stay out too late and the like)." It does not occur to them that the instructor might be asking for a list of everyday repetitive behavior such as time of rising, regularity in attending classes, and the like. Apparently "habits" are considered synonymous with behavior to be avoided.

2. Family and School Influences

Many investigators have emphasized the relationship between the problem behavior of children and the unsolved tensions of the adults in the home. Levy^{25 26} has studied the response of children to expressed or implied parental preference for siblings. Lowery²⁷ finds that rejection and inadequate love of parents for children is related to child maladjustment. Baruch²⁸ shows a strong relationship between parental conflict and emotional disorganization in the children. Murphy^{29 30} concludes her summary of a number of studies of family influences with the statement that in spite of the number of valuable investigations dealing with family and parent-child relationships, there is not yet sufficient information to furnish a precise or complete picture of the influence of the home nor to give "an adequate account of the many-sided impact of total family structure on child personality."

Not only does the child respond to the home atmosphere but he is subject to strong pressures about his own behavior. Some parents live in constant fear that their children will bring disgrace on the family. Since the nature of this disgrace is not specified, dread of the unknown makes the child's fear of being guilty all the more painful. A sense of being constantly on the verge of doing something wrong cannot help affecting a child's attitude toward himself by weakening his self-confidence. Thus, directly or by implication, children are taught to seek safety in conformity, withdrawing, inconspicuousness and unquestioning obedience to their elders. They learn to overestimate the wisdom of others, to fear their own impulses, and to feel safer when they are depending on the judgment of someone else rather than on their own. They feel that they must be over-modest in their expectation of success, and as a result fear to aim too high. The child who finds himself unable to act with any freedom may conclude that he is a very naughty, unlovable, or even a dangerous

person. He may come to overestimate the power of his own drives. It is as though he should think of himself as a small animal in a very strong cage. "This animal, even though he looks small and harmless," he reasons, "must be extremely difficult to control to need to be kept in a cage with such strong bars."

The young child may not become conscious of the difficulty these self-depreciating attitudes create in his interpersonal relationships until he meets conflicting demands for the first time. An initial experience of this kind is actually very different from the everyday experiences of an adult with such dilemmas. Subject as the child is to the authority of his elders, he may be greatly confused to discover that he has strong needs that are not in accord with the wishes of the adults on whom he depends, and that they can make and enforce demands upon him which are completely at variance with his own needs. In response he may blindly try out various forms of behavior that are available to him. If by trial and error he discovers one that satisfies both his own needs and the demands of the environment, his tensions may relax and he may again experience a sense of oneness with his world. Should he be less fortunate, he may try out a succession of behaviors, discarding one after another either because they fail to satisfy him or because his social environment penalizes him for them. His relative inexperience with socially accepted methods of expressing differences of opinion and desires, as well as the fact that he is permitted almost no alternative by his elders but to obey or be punished, may finally combine to give him a feeling of helplessness which results in fear and anxiety. At this point, either for lack of continued inner drive or because of overstrong outer pressure, he may settle on some partial solution. By yielding, he may reduce his acute anxiety to a bearable degree of discomfort, even though he does not achieve actual satisfaction. A balance of factors rather than any one of them may determine the nature of this compromise.

In subsequent social situations the child's behavior is determined to a large degree by these earlier experiences that he has undergone. If, for example, his parents like him better when he plays quietly without frequent demands for their attention, withdrawal may become his method for securing approval. Withdrawal may not prove equally effective, however, in making friends for him when he enters school. Unless he learns other methods of being accepted by his agemates he will be well on the way to becoming an isolate. The more he seeks approval by withdrawing, the more he is likely to be ignored, or actively "picked on" by other children who may interpret his withdrawal as a criticism of their behavior. If he tries to escape their aggressions by running home, he may be called names such as "mama's boy" or "cry baby." Thus the world of his peers may become unpleasant, and even dangerous, and his need for withdrawal may increase.

Parents and teachers play a decisive role in these early adjustments of a child to conflicting social demands. If they are able to recognize the child's difficulty in adjusting to his group, and can help him adjust in a socially acceptable way, then the cycle of frustration and subsequent withdrawal which leads to isolation may not develop. If, however, out of their own fears or their own need to overprotect, the adults agree with the child's feeling that the world is too difficult for him to master, they may encourage him to develop a permanent need for withdrawal. To encourage a fearful child to substitute individual achievement, such as high grades, for social adjustment simply deepens his fear of social living and furnishes a rationalization for not making necessary adjustments. If this withdrawal pattern is repeated, with minor variations, from year to year, the child may become progressively less interested in activities normal to his age group. He may develop a supercilious attitude toward the "foolish" activities of other children of his age and may maintain that he is not in-

terested in parties, dating or going away to college. At the same time, solitary pursuits may no longer satisfy him. At this point there is serious danger that he will be unable to make an adequate transition from childhood to adolescence and adulthood. The end result of habitual withdrawal is the removal of the individual from the beneficial effects of social stimuli which energize learning. He loses out because he does not learn the skills necessary for his further development.

Studies of maladjusted adolescents and adults repeatedly emphasize the relationship between the social environment and problem behavior. Adler³¹ was among the first to point out that the individual develops a "life style" in terms of his experiences in a world of larger and more powerful persons than himself. In a physical world where chairs are so large that the child must *climb* into them rather than sit down on them as adults do, and where persons are more powerful and adequate than he is, he must make many adaptations, some of which may become organized into the pattern of behavior which he carries into adulthood. Adler observes that childhood ends and maturity begins when the individual learns to take his place among adults with a feeling of equality. When infantile attitudes persist into later adulthood, the individual is very likely to exhibit a withdrawn or ineffectual life style.

Lewin³² points to the various degrees of freedom with which different individuals react within their "Lebensraum," or life space. Some persons are able to move about freely and to react without fear of undue pressure; others apparently have less freedom and are unable to impress their desires upon others, or to resist the attempts of others to dictate what shall be done. Personality growth, according to Lewin, is the progressive extension of the life space of the individual, and therefore those who have little freedom to act are restricted in further development.

Horney^{9 10 11} has described the cycle of repressed aggression

and guilt which accompanies the undue restriction which withdrawal enforces, as well as the cultural matrix out of which it develops. Menninger^{33 34} shows how the conflict between social demands and inner needs results in self-defeating behavior which may range anywhere from a sort of self-sabotage in everyday efforts to actual self-destruction in suicide.

None of us can completely escape certain of the cultural influences which encourage withdrawal, nor is it entirely desirable that we should. But the child who receives intelligent assistance from his parents and teachers in making adequate social adjustments without feeling too much set apart from his fellows is fortunate. The child who is neither pushed into developing withdrawal patterns for emotional security nor has learned to fear his own impulses, or those of his fellows too unrealistically, will be able to evaluate more adequately both his own behavior and that of those around him.

V. Behaviors Associated With Withdrawal

Withdrawal types of behavior are related not only to the cultural, community and family patterns in which the individual is reared, but they are associated also with a more or less typical constellation of behavior. Wickman³⁵ found that teachers tend to describe shy, withdrawing children as being unhappy, sensitive, fearful, resentful and cowardly. Ackerson³⁶ discovered high correlations between seclusiveness and such behaviors as queerness, unhappiness, listlessness, daydreaming, depression, feelings of inferiority, and repression in the groups of delinquent children he studied. Contrairiness and sullenness were also correlated with this constellation of behavior. He suggests that individuals who withdraw are not merely followers, but are isolates. Here again withdrawing behavior is found to be related to an individual's capacity for interaction with a social group.

Prichard and Ojemann³⁷ kept records of the behavior of pre-

school children who were pointed out as insecure by their teachers. These children were found to exhibit more solitary play, with fewer attempts to join the group and to receive more rejections when they did attempt to join it than was the case with other children. They made more attempts to gain adult attention, did more crying and gave more evidences of apprehensiveness than did the secure children.

Bowman³⁸ compared a normal adult control group with a group of adult experimental subjects who had been diagnosed as having a schizoid or an affective psychosis. Almost all members of the psychotic group were in the upper two quartiles in intelligence. He found among the psychotics an unusually high number of strong attachments to parents or family members. Fewer personal friendships and strong feelings of their own superiority characterized the group, as well as solitary habits of amusement formed in childhood. More than half of the psychotic group, also, had been considered close mouthed in childhood, while only 13% of the normal group had been so considered. The normal group contained significantly fewer model children and fewer who made a fuss over pain. More of the normals reported that they had experienced various forms of social and emotional satisfactions.

Studies such as those of Wickman and Ackerson mentioned above suggests that shyness and extreme withdrawal are not necessarily synonymous with meekness and a sweet disposition. For example, resentfulness, cowardliness and sullenness are found to be associated with avoidance behaviors. These findings are not surprising in the light of the emphasis placed by Dollard, Doob et al³ on the close relationship existing between experiences of frustration and aggressive behavior. These findings also indicate that the behavior of some withdrawn individuals can be expected to be characterized by contradictions. Unpredictable and sudden aggression may follow refusal to cooperate. For a time such a

person may appear quite submissive and then, unexpectedly, he may become unreasonably aggressive. Both extremes of behavior are probably due to his inability to maintain a consistent balance between his needs and the interpersonal pressures which frustrate him. He reacts with hostility because he has never learned methods of expressing, and so reducing, normal degrees of negative feeling in approved ways before his irritations have accumulated sufficiently to drive him to impulsive behavior. In a conflict situation he cannot bring himself to admit that he is upset by circumstances in which his intellectual evaluation of the situation and his emotional response to it are at variance. He is unable, however, to banish his feelings just because he deems them inappropriate. He is left in a situation where he has little recourse but to blame himself for his ineffectuality. Feelings of humiliation and frustration tend to accumulate with repeated withdrawal experiences. Under such circumstances of accumulated tensions he is likely to over-react in a wide variety of social situations, many of which may be unrelated to the origins of his frustrations. Such uncontrolled behavior may frighten him into an even more extreme withdrawal. The accumulative result of repeating this cycle of events may be that he will lose faith in his ability to live with others or to regulate his behavior as they seem able to do.

VI. Techniques Employed by Adjusted and Withdrawn Individuals

A person who has previously been successful in reducing feelings of threatened inadequacy and loss of status by adequately solving his problems, has the advantage in subsequent crises over the one who has become withdrawn and fearful as a result of repeated failure. The former has developed attitudes toward himself and toward problem-solving of which the latter may be largely unaware. It seems reasonable to believe that the tech-

niques employed by well-adjusted persons might profitably be pointed out, or even taught to others who show a tendency to meet their problems by withdrawal. What are some of the differences between the techniques employed in interpersonal relationships by well-adjusted and by withdrawn individuals?

For all human beings, living is a continuous process of psychological, emotional and biological adjustment. For an individual to be considered "well adjusted" does not, however, necessarily imply that he will know the correct thing to do and do it under all circumstances. Such a standard is so perfectionistic as to be impossible. What is meant by designating an individual as well adjusted is that he is willing to seek, as well as to accept, help from others who may know more about his specific problem than he does. His underlying attitude is one of confidence in his ability to meet reasonable demands either by means of his own resources or with assistance. He is familiar with conventional social behavior patterns and is flexible in applying them to new situations. He need not be afraid of making mistakes, because he looks upon errors as inevitable to the learning process, and so he is not driven to self-rejection if he finds that he has made a few blunders. His compliance is based on a cooperative attitude rather than on an attitude of possible obedience.

The well adjusted adult has many conscious techniques for meeting demands with which he is unwilling to comply; therefore he is not thrown back on purely resistive behaviors such as the unconscious withdrawal mechanisms. When confronted by a pressure situation he may react in any of a number of ways. He may refuse outright, with or without stating his reasons. He may make an acceptable excuse for not doing as he has been asked. He may leave the situation. There are many forms of avoidance behavior which are considered normal, since a certain amount of face saving behavior is commonly accepted in our culture as a

sign of social intelligence. The well adjusted adult, therefore, has developed methods of reaching a practical balance between outer pressures and his own desires, thus avoiding extreme fear and anxiety. He can meet ordinary conflict situations with directness. He is not driven to employ unconscious defense mechanisms.

The behavior of the person who attempts to adjust by withdrawal under pressure differs in many respects from that of the well adjusted adult described above. Although both are frequently faced by situations which require them to make adjustments that may not be easy, the one who employs withdrawal as a defense does so out of the fear that he is incompetent rather than because of the difficulty inherent in the task. He lacks confidence in himself and fears to show himself to be inadequate. As we have seen, this fear may be the outcome of previous failure on his part to master conventional patterns of problem solving, which make it possible for others to succeed where he fails. His withdrawal behavior in previous situations has served to reduce his feelings of helplessness but it has not given him a sense of ability to master circumstances. However, since withdrawal has furnished him the only relief of tension which he has been able to experience, he tends to use it increasingly and in circumstances in which it is inappropriate. It may finally come to dominate almost his entire adaptive response repertoire.

Although the withdrawing type of defense behavior is considered to be a type of anxiety reduction, reduction of tension may be quite incomplete. Many persons, after having been particularly inadequate and withdrawn in a situation which affected their feeling of status and self-respect, suffer prolonged periods of acute anxiety, tension and self-recrimination. The sense of inadequacy may be so painful that the person rejects entirely the idea that his own withdrawal behavior was responsible for his loss of social status, and convinces himself that he has been rejected by others. He points to the unfriendly and

sometimes hostile attitudes which he has aroused in others and insists that these are the cause of his behavior. He comes to think that other people have, for no good reason, or for inexplicable reasons of their own, chosen to ostracize him. Painful as this thought is, it may be less devastating than to accept the fact that his own insufficiency has brought about his isolation.

VII. Therapy for Withdrawal Forms of the Defense Mechanism

Since subsequent chapters are to be devoted to discussing various methods of psychotherapy, it will not be the purpose of the present section to do more than high light certain methods and their application to the specific requirements of the patient whose behavior is characterized by pathological withdrawal. Therapeutic methods may be divided into two types, group therapy and individual therapy, depending on whether the therapist deals with the patient individually, or whether he places the patient in a group situation in which the latter's role may be either that of auditor or of participant. The two types of therapy may be used concomitantly with the same individual.

Modification of the withdrawal patterns of behavior of an individual may require more than psychological-psychiatric treatment. Withdrawal behavior, based as it is on lack of stamina to solve conflicts by a frontal attack, is often found associated with such physical conditions as low energy, malnutrition, glandular insufficiency, and chronic fatigue, among others. In the psychosomatic field it is not always possible to determine which of the two mutually contributing sets of factors (e. g. physical and psychological) have initiated a given disturbance, nor is it usually essential to decide this priority before commencing therapy. Whether psycho-therapy is undertaken by group or by individual methods, the medical aspect of the individual's condition should be taken into careful consideration in planning any treatment program.

A. Modification of withdrawal patterns by group methods. Although withdrawal behavior may become an habitual mode of response to widely divergent stimuli, there is evidence that under certain conditions the individual can learn to substitute for it, other, more aggressive forms of behavior.

A study of an attempt to modify individual withdrawal behavior in a group situation without the use of individual counseling interviews has been reported by Lowenstein and Swendson³⁹ in an eight-week camp program for children from six to ten years of age. The experimenters were able to see considerable improvement toward social participation in the behavior of shy children. They felt that the critical aspects of the experiment were the daily contact with other children in an atmosphere in which the program was child-initiated rather than adult-dominated.

Keister and Updegraff⁴⁰ studied the reaction to experiences of failure of an experimental group of school children. They found that after specific training the children tried more persistently, showed more interest in solving problems, and no longer manifested emotionalized reactions to the situation.

Green⁴¹ and Prescott⁴² present methods of using public school classes as centers for training children in less withdrawing forms of behavior as well as improving their mental hygiene adjustment in other areas.

Baruch⁴³ reports success in modifying the withdrawal behavior of teachers in training for nursery school work. Interviews with these advanced students formed an integral part of their practice teaching, and were in many instances initiated by the student herself rather than by the staff.

Bagby⁴⁴ found that he was able to secure group acceptance and cooperation in the case of a boy whose terror of other children resulted in such extreme withdrawal that he had formed the habit of waiting after school until the other children had gone home and then running madly through alleys to reach his own

home. To modify this behavior, the psychologist privately taught the boy to be unusually accurate in "shooting baskets" in basketball. During a critical school game, he arranged for the boy to play long enough to make the winning point for his school. His schoolmates were both surprised and pleased at his ability. With some additional coaching in group behavior, the boy's withdrawal patterns gradually gave place to a more aggressive, outgoing adjustment.

Group methods of modifying maladaptive response patterns have been increasingly employed in recent years. Moreno⁴⁵ used the term "affective re-education" to describe the fundamental principle of "psychodrama," a method he employed with children in Vienna as early as 1911. The method is capable of numerous modifications, but essentially consists in having the patient take a more or less structured role in a dramatic situation devised by the therapist or set up under his direction. The patient may play the role of himself, or of some person related to his real life situation, or he may enact a monologue, or take the roles, alternately, of several persons in a situation; or cooperate with other actors. These others may also be patients, or they may be the therapist's assistants. There may or may not be an audience present. In some instances, recordings are made of the words spoken, and these records may be employed as the basis for later therapeutic interviews.

Moreno brought his methods to the United States in 1915 and built the first theater for use with psychodrama. Other workers have employed similar forms of group treatment with persons suffering from many kinds of maladjustments. However, group methods of treatment have been carried on most intensively with children, college students, and in veteran's hospitals. Lazell,⁴⁶ Schilder,⁴⁷ Slavson,⁴⁸ Redl⁴⁹ and others have reported that their findings tend to support the belief that excessive use of withdrawal behavior is learned in early childhood and that it can be

modified by subsequent, more favorable group experience, combined with individual methods of increasing insight into social interaction.

B. Modifications of withdrawal patterns by individual counseling. Group and individual therapeutic methods are similar in that both attempt to utilize more or less "controlled" types of interpersonal situations as means of changing human behavior. Individual methods probably permit a higher degree of control of the treatment situation than do group methods. However, except for the number of persons involved in the process, they have much in common. Both methods are often used in combination, or as supplementary one to the other. In face it appears that one of the important criteria in judging the adequacy of a remedial program is the variety of effective methods and resources that the therapist has at his command. Although neither individual nor group procedures have as yet been adequately validated experimentally, both are attracting the attention of persons interested in investigating their effectiveness as well as their theoretical foundations. So far, the pragmatic test is still the chief criterion of the validity of personality remedial measures of most kinds, and case studies of the "before and after" type are the usual method of reporting the results of therapy.

Psychotherapy as applied to extreme withdrawal types of adjustment is discussed in the greatest detail in the literature dealing with schizophrenic and pre-schizophrenic conditions, while the preventive aspect of the problem is emphasized in mental hygiene publications. A large number of the clinical techniques described in connection with forms of maladjustment not primarily characterized by withdrawal behavior are appropriate as well for use in this condition. Such discussions of psychotherapeutic techniques as those of Allen,⁵⁰ Rogers,⁵¹ Schilder,⁴⁷ Taft,⁵² A. Freud,⁵³ Thorne,⁵⁴ Masserman,⁵⁵ Maslow and Mittleman,⁴ Stogdill,⁵⁶ Fromm-Reichmann,⁵⁷ Weiss and English⁵⁸ and

a host of others, also present a variety of clinical methods appropriate for use with problems involving withdrawal behavior.

1. Murphy's Three Steps in Therapy

Murphy⁷ has given a clear picture of the steps that must be taken in helping the withdrawn patient. He says that since it is one of the characteristics of withdrawal to limit a person's experiences and thus his learning, there is likely to come a time when the patient finds himself blocked from making any effectual effort to get himself out of his dilemma. If he is ever to be rehabilitated, someone else will have to take the initiative. Murphy enumerates three steps in the process of counseling a withdrawn patient: first, the clinician must make contact with the remaining areas of security in the patient's life; second, he must arouse or train him to have some feeling for others and last, he must help him to gain insight into the mechanisms he tends to employ in his attempt to escape from his difficulties by withdrawal behavior.

Perhaps if we elaborate a little on these points it will be helpful. The conventional procedure of securing a case history as early as possible in a contact is given a new meaning when one is studying a withdrawn individual's life history for the purpose of "making contact with his remaining areas of security." "What are or have been the areas of security in his life?", and, "Did he ever feel 'as other people do'?", are questions which reveal more about this type of case than do the usual interrogations of the case history. Perhaps the client will be able to remember a time in his early childhood when he felt accepted. It is easier to help him increase his present courage if he has once felt that he succeeded in some relationship, no matter how small his triumph may have been. Building up contacts with him at points at which he had experienced positive approval and some outgoing feeling puts the patient in a more secure position than if one started working with him at his points of greatest tension. He can be

helped to see that feelings of security have causes which can be analyzed and understood. Of course, the clinician might also attempt to begin his work by showing the client that feelings of fear and insecurity have causes that can be analyzed and understood. This second statement is equally true, but it is undesirable to emphasize it because it focuses attention on painful aspects of the client's emotional life. Therapists who have worked with amputees say that their greatest problem is to get the patient to thinking about what he can still do, rather than worrying about the functions and parts of his body that he no longer possesses. It is even more important with the withdrawn individual whose whole emotional life is a retreat from possible pain, that his clinician should approach him on the positive side. The patient's courage in the present situation as well as in future ones should depend not on his reliance on his clinician, but on how well he can learn to rely on himself through the clinician's encouragement. There is a vast difference between encouraging a person to rely on himself, and temporarily serving as an emotional crutch on which he may finally come to be more dependent, and so less adequate, than before therapy began. The client needs to feel that the clinician does not look on him as impossible, but believes that he can make a satisfactory adjustment if he is willing to work at it. If this belief is emphasized by the fact that the early interviews have centered around his successes, and the times when he felt accepted, the client may not need to experience an extreme dependence on his therapist, but can begin from the first interview, to rebuild his security in his own right.

Later in the progress of the interviews, it may be necessary also to discuss incidents of remembered insecurity. It is frequently possible in going over such experiences, to clarify them to a considerable extent. The patient's original interpretation of such experiences as well as his memory of them, may have been distinctly colored by negative self-feelings that were already be-

ginning to crystallize in his mind. In the light of the acceptance he feels from the analysis of the positive side of his personality, he may now be able with a little encouragement to see these early experiences from a considerably different viewpoint. Some remembered remark, for example, which long ago caused him to brood and feel rejected, may now be seen as having been the outcome of the emotional bias of the speaker, whom the client can now begin to see in a more realistic light as his own tensions are reduced. The process of clarifying memories and attaching to them a more objective feeling-tone is not a simple one, nor one which can be done hastily. The patient may require many interviews and a long acquaintance with the clinician before he can acquire the degree of confidence in another human being requisite for him before he can enter into a really confidential relationship. One must never forget that the withdrawn patient is deeply sensitive to the slightest breath of criticism, and that he can sense negative attitudes in others at very incipient stages of their development.

Some patients find it easier to start talking about the times in their lives when they felt threatened, since they think of the clinician as one chiefly interested in their troubles, and are inclined to resent the attempt of anyone to give any positive encouragement. In their bitterness they have protected themselves by considering all such kindly approaches as attempts to trick them. Withdrawn patients are often quite self protective and reluctant to give out any kind of significant information about their inner lives. This is especially true, understandably enough, when they feel a strong urge to trust someone. Under such an impulse toward the clinician, they feel they must guard themselves even more than usual, in order "not to make fools of themselves" or betray themselves into revealing their overwhelming fears and needs. As a result they are likely to "try out" the clinician repeatedly under all sorts of pretexts in order to satisfy themselves

of his personal and professional integrity and his ability to maintain a consistently understanding attitude.

Many a withdrawn patient has endeavored by reading semi-popular psychological and psychiatric books and articles to solve his own problems before consulting anyone else about them. As a result he may have come to believe that a single traumatic experience must be discovered in his past life which changed his outlook from happiness to misery in a brief space of time. If he is unable to remember any such incident, he may fear that he cannot be helped, because he knows so little of psychotherapy as to be unaware of other approaches to the solution of his problems. Accordingly he may actually invent a fictitious traumatic experience, or overemphasize the seriousness of some actual occurrence in order to cooperate with the therapist. This exhibits a typical form of withdrawal behavior, i. e. behavior deviating from the facts to fit a preconceived pattern believed to guarantee safety.

Getting to see the client's life from his point of view is not only the first step in therapy, but is the foundation of all therapy. Patient, persistent good will are required to develop a relationship of confidence that will bear the demands therapy will make upon it. It is evident that the longer a withdrawal attitude has persisted, the more deeply intrenched it will have become. The more an inner world has been elaborated, the more there will be to understand about the patient's private outlook on life. For example, in order for the clinician to understand his client's communications adequately, it is often necessary for him to learn a fairly extensive vocabulary of words which, though not uncommon, are used in a private sense by the client. For example, one young man used the term "ringing words" meaning those which had a particular emotional content for himself in his inner, emotional world. He also spoke of "being patriotic to myself" when he meant not permitting himself to be bribed to leave his phantasy world by temporarily affectionate behavior on the part of his

father, for he had learned that to do so meant to be hurt again as soon as his stepmother demanded his father's attention.

The inner world of the withdrawn person has been made more understandable through semantic studies such as those of Korzybski⁵⁹ and Johnson.⁶⁰ They show how the failure of an individual to relate words adequately to events and things around him can result not only in temporary confusion, but in even more serious disorganization. Hayakawa⁶¹ points out the relation between the mis-communication caused by highly symbolic or personal language symbols, and personality maladjustment. For example, the young man referred to above who employed the term "ringing words" did not react to their use in the same way that any other person would. They "meant" different things to him than to others because of a private context they had come to have for him out of his experiences. The clinician who understands this sort of communication can make allowance for the difference in speech between him and his client, and can learn to translate his client's communications so as to understand his real meaning. Moreover, the clinician can help the client to clarify his communication with other persons.

Hanfmann,^{62 63} Kasanin⁶⁴ and Hinsle⁶⁵ among others, have given considerable attention to the type of logic employed in his inner world by the schizophrenic and by other withdrawn individuals who are not yet so far withdrawn from reality. Each of these processes observed in their studies. They also emphasize the fact that, although it is theoretically possible to make contact even with the schizophrenic, and to help him restructure his thinking in more normal ways, one cannot count on "unlimited elasticity" in the response of persons past early adolescence. This emphasizes the urgency of helping children establish courageous, socially participating attitudes, free from fear and from the need to build up a private world in compensation for the inadequacies of their early emotional experiences.

It should be clear that even when the clinician knows a great deal about his client's life history, and understands clearly the ways he thinks and the terminology he employs, he has barely made a beginning at assisting his patient to function freely in competitive social situations. This brings us to the second point made by Murphy:⁷ the necessity of arousing or training the patient to experience social feelings. This process commences when the client comes to the counselor. Even his decision to seek help is a definite reversal of his withdrawal pattern. His first contact with the counselor is an attempt to communicate rather than to withdraw whether or not the client is clearly aware of this fact. Many persons come to a psychoclinician with a sort of belief in his having superior powers. The "cure" is thought of as coming entirely from without the patient, perhaps as a sort of "magic." The client is certain that it is the clinician who will effect the change. In early interviews it is sometimes very difficult if not impossible to get some patients to accept any other interpretation of therapy. This is particularly true of certain highly intelligent students who have read somewhat widely, but rather exclusively in the semi-popular accounts of abnormal psychology, psychotherapy, or self improvement. They feel that they know all about what makes people maladjusted, but assert rather complainingly that it has not done them any good. Their over-compensatory feelings of self-assurance cannot permit them to face the fact that other mere humans can know and do what they themselves cannot. Therefore the psychologist in their opinion, must be a superman. Only their need of help, however, makes tolerable to them the idea of seeking assistance from any other person and so revealing their own need. This conflict is one of the sources of the ambivalent behavior and attitudes of certain patients toward clinicians.

The skillful psychotherapist will evade the question of his role of "worker of miracles" for at least several interviews, if pos-

sible. He can explain to the client that they are comparative strangers to each other and point out that obviously the more he understands the client's background and how he feels about things, the more helpful he can be. This viewpoint is usually accepted without difficulty, although the material the patient discloses at first may be presented at a somewhat superficial level. Occasional interruptions by the clinician with tactful questions calling for somewhat deeper analysis of motives and feelings will tend to be progressively accepted without great resistance. Sooner or later the patient may be brought to realize that his problems are being clarified, and may comment on some degree of relief of tension resulting from these "preliminaries." For example, one patient said, "I did not think you had begun to work with me at all, really, I thought this was all preliminary. I do not understand why I am feeling relief already." Another said, "My ideas of what therapy is like are certainly changing. I thought you would hypnotize me, or that you would have some definite solution to give me for my problems." Step by step, as the patient reveals himself, he finds that he is actually communicating more freely than even before with another human being and on a higher level of satisfaction. He finds himself able to say what he wants to quite freely without considering each sentence to see that it is safe to express it. He finds that his ideas are not so unusual or objectionable as he had come to consider them.

As the client develops more confidence in the essential normality of his thoughts, he may find that he can also communicate more freely with persons other than the therapist. It is well to realize that until he has reached this stage, he is not ready for attempts at social contacts. The clinician must not mistake the client's anxious feeling "I ought to be more sociable" for genuine readiness to participate. Premature sociability may not only prove unsuccessful but may discourage further attempts. If it is possible to help the client experience some measure of success in

his first approach to a wider social contact, it is well to do so. The therapist should remember that it is primarily his client's *courage* that he is attempting to build up. Successful sociability and all other accomplishments are of secondary importance temporarily at least. To keep this orientation in mind will save much misdirected effort or possible failure.

This is particularly important in dealing with individuals who have developed a cover for their withdrawal attitudes. For example a person who is always making mistakes in public, may learn to get a certain notoriety out of making a conspicuous fool of himself. He may be one type of "life of the party" but he cannot be said to have made a very satisfactory adjustment. His inner emotional problem has not been solved, and he feels as isolated as before, if not more so. To help such a person to give up his clowning and learn to achieve his recognition in other ways which will bring him friends, constitutes a more difficult problem than it might have been to help the same individual before he discovered this partial solution which he now employs.

A case of this sort is that of a senior woman student who complained that she had not made any friends in college, although a certain group of girls had tried to include her in their good times because they felt sorry for her isolation. But she had never really felt as though she were one of them, in spite of attending their parties.

She was a brilliant student, read with extreme rapidity and was clever at telling stories with a cynical, sarcastic flavor, especially those that ridiculed religion. Although her father was a minister, their home life was full of poorly concealed antagonism and suspicion that the father was unfaithful to the mother. The father was a highly dominant person who ruled his children autocratically. The children were afraid of him and were confused by what they felt to be his moral inconsistency. The daughter had learned to get attention in the community on the

basis of family status, at the same time that she ridiculed all the things for which the family was supposed to stand by virtue of the father's position as minister.

After a number of interviews had elicited the above picture, and the girl herself had expressed a readiness to attempt to meet people from a new angle, she was encouraged to arrange a party for the group of girls who had befriended her. They, however, were not told anything about her new outlook. Many hours were spent by the clinician in conference with her, encouraging her to plan in detail not only what she would wear, what refreshments she would serve, but just what she would say in greeting her guests on arrival. Every possible contact she was likely to have with her friends was carefully considered. Bridge was selected as the form of entertainment because of its highly conventionalized nature. Although the clinician was to be present, her role was to be solely that of a guest.

The party proved a success. The hostess surprised the clinician by her ability to carry out the plans they had made, and her success in refraining from her usual wisecracks. She secured attention by being a conventionally good hostess. After the guests had departed, the clinician complimented her on the success of her party, and opened the way for her to discuss the evening which she did in considerable detail.

The following day when the clinician met one of the guests on the campus, this young woman, a major in psychology, expressed amazement at the smoothness of the preceding evening's party, and asked, "How did you get her to act like that? Why, she behaved just like anybody else!" After a brief explanation, it was possible to enlist her cooperation in planning further events not involving the personal presence of the clinician. The progress made by the client with interpersonal relations during the remainder of the year was gratifying to all concerned. That the change was solidly based on self-understanding and freedom

from anxiety over her social role was demonstrated by the fact that her poise kept on increasing even after the completion of therapeutic contacts. After she graduated and returned to her home, it was reported that she made many changes in her family situation that helped to resolve conflicts which other members of the family, particularly her mother and younger siblings, had been suffering. This case illustrates a common but often unrecognized type of withdrawal behavior in which the pseudo-adjustment provided by clowning is an evasion of the need to develop satisfying interpersonal contacts.

The third step in therapy as outlined by Murphy⁷ is not necessarily third in the order of its use in approaching a given problem. The clinician must assist his client to "see through his own poses and mechanisms," but this process begins early in therapy and is seldom called directly to the client's attention at this time. As in the case presented above, attempts to develop insight are present throughout the entire course of the interviews. The degree to which the patient succeeds in achieving self-understanding may be taken as one of the primary indications of successful therapy. Baruch⁴³ refers to this development as "movement" in a case. All methods employed to reduce fear, decrease unreasonably severe standards, raise self-esteem, augment physical energy by referring the patient for competent medical care, and the like are undertaken for the express purpose of aiding him to re-examine his life in new perspective and to reconstruct his behavior accordingly in more acceptable forms. Examples of the differences in the attitudes of certain patients "before and after" acquisition of insight into their withdrawal behavior are presented in the following paired statements taken from actual case notes. "Other people do not like me," changes with self-insight into, "I guess I have never liked other people, so why should they like me?" "My parents never gave me half a chance," becomes, "My parents had no chance to know better

than they did, but that does not need to prevent me from learning to do better than they knew how to do." "I am not attractive, so how could anyone like me?" changes to, "I guess if you are kind and understanding with others, they will like you all right." "I should like to be a writer, but I do not think my stuff would be appreciated," becomes, "I have never dared write down the thoughts which seemed so valuable to me for fear they would appear pitiful and then I would be ashamed and think I was not worth anything." Behavior based on the second of each of these pairs of statements would obviously be quite different from that based on the first of the two. Certainly it would prove more realistic for the purpose of making friends and feeling accepted and acceptable to those in the environment.

VIII. Summary Discussion

A. Problem of Conformity and Initiative

One of the problems which arises from our living in group fashion is that certain of the patterns of behavior which are developed for the control of individual members of a group in the interest of the whole may be mutually conflicting. For example, conformity to rules or obedience to authority on the one hand may conflict with individual initiative or enterprise on the other. Yet both conformity and initiative have value for the individual at different times and in various situations. If he is free to judge new situations on their merits and to decide which of these extremes (or combination of them) is suitable for the particular occasion, he can behave appropriately, and we say that he is a well adjusted person. The same principle holds for many other forms of social interaction.

The degree to which a person is free or able to adapt his response to particular situations, or to put it in another way, the extent of his freedom from stereotyped response, is an important factor in determining the degree of mental health he can main-

tain in the face of conflicting demands. Individuals of normal intelligence vary considerably in flexibility even in their early infancy. This fact has led to the belief on the part of some scientists that heredity is the chief factor in determining whether a person will be able to establish and maintain a well balanced adjustment. Other observers of the same phenomena consider that learning plays a more significant role than inheritance. The final answer to this difference of viewpoint has not yet been given. The Mental Hygienist, however, finds that by considering the problem from the "learning" approach, he is able to increase his understanding of human behavior and his ability both to predict and to modify the response of the persons whose behavior he is studying. The point of view of this chapter emphasizes the role of learning in human adjustment.

The need of the small child for affection, security and approval causes him to be especially responsive to modification of his behavior in this early period of his life when he is dependent on his parents and other representatives of society charged with the responsibility of his acculturation. So great is the strength of this influence that it may be employed to make or to mar the child's adjustment.

As the child grows older, it can be observed that he normally takes over the control of increasingly larger areas of his own behavior. The standards upon which he decides the value to be placed on various actions, and his methods of solving conflicting demands are those he has been taught, by experience, or modifications of them. We say that he has begun to internalize social and cultural demands in terms of a conception of "self-in-society." His playmates have had essentially, but by no means identically the same background experiences in their homes. Interaction in play groups further widens the child's conception of what constitutes acceptable behavior. His "self-in-society" concept is not a static one, but is constantly being modified by life

experiences; it is not necessarily verbalized to any extent, nor is his idea of his place in the group clearly conceived. He will be most definite as to his proper role at those points concerning which there is the least disagreement among his early instructors (including parents and siblings). From primitive times men have observed the existence of such a self-picture and have called it conscience, ego, super-ego, inner light, as well as other more scientific and less judgmental or moralistic terms.

B. Loss of Initiative Concomitant With Neurosis

The immature individual, regardless of chronological age, finds that he has two courses of action in regard to a cultural law or custom: he can be obedient or compliant; or he can be disobedient. He will be rewarded, or at least will usually not be punished, for obedience. He may be punished or even ostracised for lack of compliance. In a relatively simple or uncomplicated situation, little need may arise for him to behave in ways that call for more than applying the existing rules. As the complexity of his situation increases, however, it becomes more difficult for him to know what to do. When the nature of the situation is such as to put a person's internalized self-picture in jeopardy, he anticipates criticism and even rejection should he make a response that would be deemed foolish or wrong. His conflict in such a situation would be all the more extreme if he believed that he could not openly express his difference of opinion, viewpoint, or desires in the matter. If all possible alternatives will bring him equal distress, it is easy to understand the pressure he feels to avoid the whole situation by some form of indirection.

As long as an individual is free to react directly either in a positive or in a negative way to the stimuli with which he is confronted, his behavior is not usually considered neurotic, even though it may be highly ineffectual or even delinquent. When, however, he finds himself in a situation where all courses of ac-

tion are equally likely to lead to serious difficulty, then he is forced to think of himself as an actor who is being observed most critically, and the focus of his attention is diverted from the *problem* to *himself*, and he becomes "self-conscious." His behavior from this point on is directed to a problem different from the original conflict, and becomes "what can I do to escape the disapproval and loss of self esteem that is certain to result no matter which way I solve the dilemma." Since each of us has his own picture of "self-in-society," the response to a threat of the integrity of this concept is likely to be more personal than our response to any external stimulus, and so neurotic behavior has a more private character than normal responses do. Plant⁶⁶ says that at this point the individual ceases to "have problems" and himself becomes a problem.

The child who is taught either directly or by inference that there are authoritative solutions for all situations and that when in doubt as to the proper course of action refraining from any action will be acceptable, has been started on the road to neurotic adulthood. The opposite of such rigid and authoritarian upbringing is that in which the child is encouraged to view each situation as calling for thought on his part as to what should be done, rather than looking to some external source of authority. The child who is learning to think out possible courses of action does not necessarily have to ignore the fact that other persons may have more and better information than he has. He need not lose respect for his elders. On the contrary, a genuine appreciation of the social heritage of the human race develops more fully in the light of free problem solving than is ever possible under an authoritarian regime.

The type of withdrawal behavior that constitutes a defense mechanism is encouraged by a situation in which there is strong outer control of individual behavior. On the contrary, the ability to think freely about problem situations and to have many al-

ternative solutions from which to choose, eliminates to a considerable extent the necessity for self-deceptive indirection.

It is possible for the therapist to assist maladjusted, or neurotic individuals to develop better adjustment, in many instances. It is more desirable, however, that the initial training of a child should equip him with courage, independence, initiative, and a realistic appraisal of his environment as well as a type of life philosophy which is not dependent upon fear of adult or supernatural controls as the ultimate source of authority and punishment. Flexibility, cooperative attitudes, appreciation of cause and effect relationships in nature, and such use of symbols as will focus his attention on operational concepts will obviate much of the necessity for experiencing confusion in the face of conflicting demands.

The use of fear and threats by parents and teachers as forms of enforcing commands, and particularly the threat of the withdrawal of love on the part of the parent of the small child, is one of the most fertile sources of neurotic attitudes. Regardless of whether introvertive, withdrawal behavior is native or acquired, we have ample evidence to show that the type of relationship between parents and children, the degree to which children are taught to look to others for the solution of difficulties, and the invoking of an undue amount of fear and anxiety in the socializing process, all have a profound effect in encouraging and maintaining neurotic withdrawal.

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Chapter VII

LEGAL AND SCIENTIFIC CONCEPTS OF
MENTAL ILLNESS

By GLENN D. HIGGINSON, Ph.D., Psychologist
University of Illinois, Urbana, Ill.

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CLARENCE B. JACKSON, Ph.D., Psychologist
University of Illinois, Urbana, Ill.

Chapter VII

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By GLENN D. HIGGINSON, Ph.D., Psychologist
University of Illinois, Urbana, Ill.

I. Law, A Functional Product of Man

Psychological phases of the institution of law concern human beings' attitudes and aims, thinking and understanding, feelings and actions in terms of the "what" conditions and the "how" (causes) including those leading to abnormal functional behavior in crime. Collective delegation by individuals to individuals to control individuals in their relationships with individuals is the essence of the law. Thus, certain men are selected by society to serve as its agents. The duties of such agents are concerned solely with those specific privileges of individuals which emerge in a social group. All duties and all privileges derive their significance in terms of one desired end, namely, conformity to expressed wishes, standards and codes of society. Laws are aimed at simplifying life relationships and at increasing degree of order and efficiency in group living. The trend toward increasing life complexity at a psychological level is balanced in part by creation of new rules and regulations—these are but one expression of the individual's struggle for sources of satisfaction classed under such heads as life, liberty and the pursuit of happiness. Different problems here concern (1) ways in which the tools of legal agents of social control emerge, (2) causes of conflicting (social) relationships, and (3) methods of discovering

and of removing (controlling) such causes. Our task is directed at describing various features of the legal institution in terms of cause and effect relationship. Good and bad values are not raised; that is, we do not say that some criminals are good and others are bad.

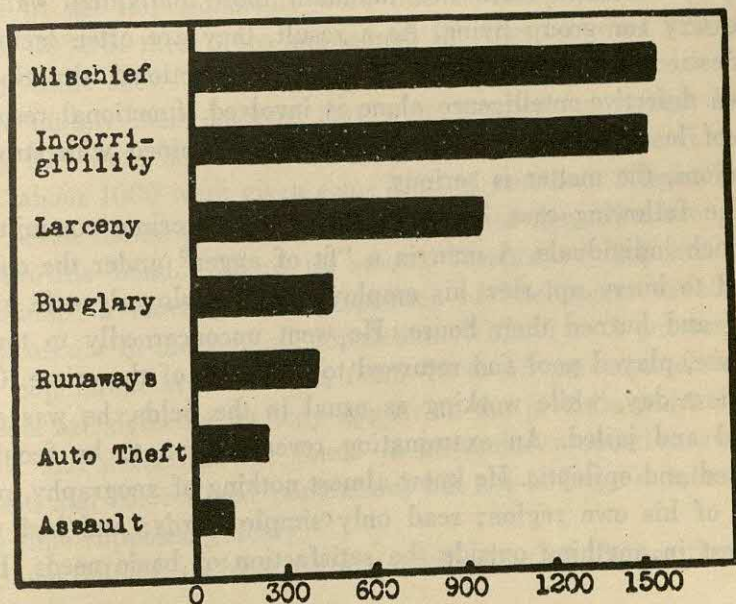
There must be a "law" limiting actions or defining privileges before there can ever be a "crime." Thus, when the prohibition law became effective many persons who had made their own alcoholic beverages immediately became "potential" criminals, who upon arrest by some one and conviction by some one became criminals. For a long time, men worked children in factories. Then a law was passed and some one complained about a particular factory. The conflicting "interests" of the factory owner and of society made a criminal or a martyr of him. Thus every "law" is a functional product of man. It is created through his *imagination* and *understanding* to regulate *actions* affecting certain human relationships. Every law *arises from a recognized human need*. Such need may be to prevent further change (stand-patters on the Constitution), to gain an advantage for a favored few (exemption of college professors from income taxes), to penalize a race (skin color as basis of right to vote), to improve morals (no drinking, dancing or playing dominoes), or to raise money (tax on dining, playing and getting married). Furthermore, the legal maxim "ignorance of the law excuses no one" shows that laws are directed to men and it is their "duty" to learn them, if they have sufficient ability—intelligence! Moreover, the application of laws and the settling of conflicts are done by men with specialized training.

II. Background Conditions of Many Criminals

A. Pathological Criminals

Intra-Organic Conditions. Every adult may become a criminal. Whether he does or does not depends upon the causal factors

found in his heredity, training and environment. Any one of many conditions here may produce violation of society's standards. Each, however, must so affect man functionally; for law is never concerned with structure. Although heredity plays an important role here, it never directly determines crime. Science has found no criminal gene to cause man to "act" against society. There is, of course, functional determination. Heredity limits imagination and understanding, decides emotional equipment and influences resistance to suggestibility. The degree of possession of inherently determined functional traits "contributes" to anti-social actions, as in feeble-mindedness, psychopathology and emotional instability. "It is not the criminal's fault," Wensley,¹ Chief Detective Inspector of Scotland Yard writes, "that conditions have moulded him wrongly. There are incorrigible criminals but there are no born criminals apart from those who are psychologically defective." Among the legal classes of delinquency and crime, incorrigibility ranks high, as is shown, for



instance, in the preceding figure. The maximal age for malicious mischief is fourteen, for petty larceny and assaults, fifteen and for crimes against property sixteen.

Intelligence is always a factor in effective social living. Persons with less intelligence are not functionally equipped to meet complex conditions of life in a socially desirable manner. One possible cause of the large differences between male and female rate of crime and delinquency (as shown in figure 1) is differences in degree of intelligence. Although many idiots and imbeciles are institutionalized, many feeble-minded occur in the population at large, where they occasionally commit serious crimes. The moron, who is less frequently institutionalized, commits many criminal acts. These, generally, are of a minor or a major sort. They are either petty crimes against property or of serious offenses (sexual, homicidal) against persons. Feeble-minded individuals lack sufficient understanding and imagination to realize possible social and personal consequences of their acts. They can neither learn nor maintain those individual values necessary for group living. As a result, they are often lacking in desired control over their activities in emotional situations. When defective intelligence alone is involved, functional results are of less consequence. But where it is combined with strong emotions, the matter is serious.

The following case illustrates one kind of crime committed by such individuals. A man in a "fit of anger" under the command to hurry up, slew his employer, his employer's wife and baby and burned their house. He went unconcernedly to town and ate, played pool and returned to the scene of the crime. On the next day, while working as usual in the fields, he was arrested and jailed. An examination revealed him to be feeble-minded and epileptic. He knew almost nothing of geography, not even of his own region; read only simple words; and had no interest in anything outside the satisfaction of basic needs. He

was totally indifferent about the crime and showed more interest in the dinner hour than anything else. A later jury held that a man who could earn fifty dollars a month as a farm hand could not be feeble-minded and must therefore be responsible for his action. He was duly convicted and hanged. "Society lost nothing in his death, but erred in failing to recognize in him the potential criminal requiring only a relatively simple set of circumstances to turn him from a stupid, harmless ranch hand into a criminal," lacking sufficient understanding to run away.

Thus, an outstanding writer remarks that many penitentiary sentences are being served by those not endowed with enough shrewdness "to get away with" crime, not financially able to have good legal defense and not energetic enough to move after committing a crime. In this connection, one study reveals that of 14,709 prisoners in jails and houses of correction, 12,124 or 84% were there because they were too poor to pay the small fines imposed upon them. Over a period of four years 87 per cent of all imprisonments were due to non-payment of fines. Over 50% of these were imprisoned for fines less than \$20. Another study shows that 8,593 persons held in jail during one year were mainly there because they were too poor to furnish bail; only 219 were held on nonbailable offenses. Of the total number, about 1000 were given some kind of sentence. "The remaining seven thousand did a jail term because they were too poor to provide bond." There is, among "caught" delinquents and criminals, a much greater proportion of intelligence defectives than occurs in the general population. While 1 to 3 per cent of the population are defective, from 10 to 15 per cent of delinquents are defective as they appear in the juvenile court. Data show that defectives are found in an undue proportion among prison and correctional populations but not in large numbers as one time supposed (Healy).²

Some individuals have average intelligence but are emotionally

unstable. Some resemble persons with high blood pressure who easily become enraged in situations which have less effect when pressure is less. Sex crimes and murders are often committed by emotionally unstable individuals. Hill, head of the Eastern Federal Penitentiary states that of all prisoners, murderers make the most reliable prison trustees; they are usually persons who acted under emotional stress. In this connection, Wesley writes: "I have never been a believer in capital punishment for all kinds of murder. Many murderers have passed through my hands. Some have thoroughly deserved to hang, but others have clearly been victims of circumstance—men or women who have killed under some sudden overmastering passion. The great majority of murders are crimes of impulse. If capital punishment were abolished tomorrow, I do not believe crimes of this sort would either increase or decrease."

Under such major psychological diseases as paranoia, dementia praecox, manic-depressive and paresis, individuals may commit serious crimes. In paranoia, an individual may labor under delusions of persecution. He may attribute his persecution to some individual and attack him. Dementia praecox may bring an inability to feel pity or sympathy. An individual who interferes with satisfaction of desires may be attacked without any apparent hatred. A Chicago man returned to his home after serving as an officer during World War I. He became attracted by a girl, and, because his wife stood in the way, she was brutally murdered. An attorney, a few years ago, chopped off his wife's head, burned her body in a furnace and cemented her head in a block of concrete. These men had dementia praecox.

Extra-Organic Conditions. Through thwarting strong desires and exaggerating conflicts, lack of money produces much anti-social behavior. The Home Secretary of England has reported a steadily increasing burglary rate over a period of years due in part to increased need. He pointed as supporting evidence the

fact that the more serious crimes remained unchanged during this period. Moreover, a drop occurred in crimes by old persons with reduction in economic need through increased dole, pensions and other public aids. The preceding figure indicates the rate of increase in burglaries in England. In this country, relative economic inequalities determine anti-social behavior. The 6,000,000 families with incomes of less than \$1,000 per year and the 12,000,000 families under \$1500 as reported in the boom year of 1929 by Brookings Institute account in part for the increase in crime in this country (as shown in diagram 2. 1936). Relationships revealed between lack of many necessary conditions of satisfaction and character traits lend further support here. A study of children from two economic levels shows, for instance, that as they go through school those from higher levels become more *consistently honest* while those lower levels become more *consistently dishonest*. A writer here comments that: "If wealth is the mother of vices, poverty is the mother of crimes." It is difficult, however, to establish a direct relation between poverty and all crimes such as murder, bigamy and rape. In some crimes, lack of money stands as a major form of determination; in others it is, at least, a remote factor.

A study of 1001 cases of embezzling gives the following description of the typical offender and a table of personally cited reasons. A complex of causes not found in the lives of most men and women must have operated in these cases. Most persons never face such changes. "The typical embezzler (the average) belongs in the white-collar class. He is 36 years old. He is married. He has a wife and two children. He is not psychopathic or of feeble mind, nor does he live in a neighborhood where crime is widespread. His upbringing has been good. He is not the lowest-paid person in his employer's organization, nor is he the highest. His friends and very often his wife imagine that his salary is \$300 a more or more, but it is nearer \$175 a month.

He has a high school education. He lives comfortably. He has a medium priced automobile, last year's model, on which a balance is still owing. His traveling has been confined to occasional week-ends and a two-week vacation in the summer. He is a good mixer. He participates in social and community affairs. He enjoys a good time. He likes a drink, but he rarely takes it during business hours. He lives in every state in the Union, in every province in Canada, in large cities, in small cities. He is employed in every type of business. He is competent and smart. He has held his position for five and a half years. His employer regards him favorably. His sons or daughters may become pressing social or financial problems. His wife may be unfaithful, or he himself may fall victim to a consuming infatuation for another woman, which will cause him to spend recklessly. On the other hand, he may succumb to an over indulgence in liquor—to gambling or speculation—'dipping into the till' or 'kiting' his accounts to satisfy his thirst or recoup his losses. In ninety-nine times out of one hundred he is 'temporarily borrowing' and would indignantly deny that he is a thief. Frequently an unexpected emergency, created by death, sickness, or personal financial loss he claims as the cause for committing his first but fatal defalcation. He meant to borrow only until the next pay day. After which he may continue for a long period, hoping that some fortuitous circumstance will extricate him from his trouble. When finally he finds himself hopelessly involved your typical embezzler is much more likely to commit suicide or break down and confess than he is to abscond. If he does abscond, however, it is usually 'with the other woman.' When brought to book he has little or none of the property or money which he embezzled."

B. Crime and Unpreventable Agencies

No one doubts that crime also stems from the functioning of those agencies concerned with guiding youth. The failures of

such social agencies as home, school and church fill our jails and penitentiaries. A well known lawyer cites the case of a young girl bandit. She was born in poverty, and later deserted by a mother who even stole her clothing from her. Thrown upon her own resources, she committed several robberies and was condemned to prison. "No record could be clearer or more eloquent. None could leave less room for doubt that Cecilia Cooney is a product of the city, of its neglect and its carelessness, or its indifference and its undercurrents of misery. We recommend her story for the pulpits, to the schoolmen, to the lawmakers, and to the social workers of New York—in short, to all those who are tempted to boast of its wealth, its magnificence and its power" (McCarthy).³ In 1936, at one time 10 persons under 21 awaited execution in Sing Sing. The number and immaturity of these murderers directly challenge society to face the realization that it has been negligent in helping provide youth with attitudes and opportunities necessary for effective living within the frame of socially accepted endeavors. Speaking of these boys, Warden Lawes said that he favors greater supervision and coordination by a federal board of the many activities within various boys' clubs. He praised the boy scout movement and boys' athletic leagues and similar groups and pointed out that they have reduced crimes of violence. He believes the whole problem should be cared for "by a government board, so that crimes can be more effectively checkmated." Since the majority of anti-social acts are done by persons in groups (60-70%), perhaps greater governmental control of youth group activities would provide effective methods of controlling human behavior. Significant here are some studies upon Scouts and delinquent Scouts and non-Scouts which show in general that "a Scout is only one-fourth as likely to become delinquent as a non-Scout." On character ratings non-delinquent Scouts came first, non-delinquent non-Scouts came next, delinquent Scouts placed third, and the delinquent non-

Scouts fell at the bottom. Groups with Scout training have a higher average of trust-worthiness than do untrained groups—and longer training here is directly associated with an increase in the degree of trustworthiness. That intelligent direction and restriction are socially desirable is implied in all attempts at formal educational control. Until experience shows otherwise, the same hold for other conditions of social living. The obligations of society to protect itself begin before birth of an individual and continue through his years. Prevention is but one form of control.

In its 1940 meeting, the American Prison Association reported that (1) delinquency and crime have their roots in social and economic conditions which can to a large degree be eliminated or improved, and in physical, intellectual and emotional factors in the individual which are susceptible to expert training and treatment; (2) that a great deal of delinquency and crime could be prevented by the expansion and improvement of agencies already in existence, and more wide-spread utilization of methods which have already been tried and proved effective, such as: slum clearance and housing programs; recreation facilities, both indoors and outdoors; public health services; guidance clinics; boys' and girls' clubs, community centers, settlement houses, and similar agencies; expansion of facilities and personnel in our public school systems to spot, guide and treat children; use of the school plant during the evening hours for varied activities under adequate leadership; strengthening of the church as a constructive power in the daily life of the individual; and improvement, by every means possible, of those home and neighborhood conditions and influences which most definitely affect children adversely. Figure 3 shows some relation between rates of juvenile crimes and city areas. Figure 4 shows differences between city and country rates at which persons are sent to penitentiaries.

Other causal conditions of anti-social activities include drugs

and alcohol. Their use serves to reenforce some and weaken other basic determinations to human action. They cause individuals to be indifferent to consequences; they rob them of abilities to "look ahead." Arousing passions, they direct men's actions in ways from which they shrink when they are lacking. Thus, every one realizes the cruelties practised by individuals under the influence of alcohol—persons devoid of sympathy, love and kindness. The following case sounds like "Tobacco Road." The wife of an impoverished farmer on WPA and mother of five children (she was a bride at 15) had a serious operation. When she returned to their small, isolated hillside farm, she expected to take it easy for a while, but her husband thought otherwise. He hitched her and their 14-year-old daughter to a heavy plow. Fortified by an explosive mixture of rubbing alcohol, plum juice, and sugar, he unmercifully beat his wife as she pulled the plow.

Murder, assault, sex attacks as well as suicides often occur under alcoholism. Drugs and alcohol produce a physiological toxic condition which in turn causes a form of functional pathology. Since this condition is usually temporary, however, common sense and law refuse to recognize any pathology. Of this point Arnold⁴ writes, "in their essential nature alcoholism and insanity are identical, and if, after a prolonged course of drink a man becomes uproarious and prone to commit unprovoked assaults, he is looked upon not as being drunk but as insane."

III. Methods of Determining Criminal Status

A. Outside the Courtroom

One major task of the legal institution concerns the determination of guilt (innocence) of individuals. Some methods of such discovery are employed outside the court room, and other methods are used inside the court room.

1. *The Third Degree*

Of the former type, the oldest method is the third degree. It seeks to obtain admission of guilt through use of pain, appeals to fear, emotional shock, suggestion and hunger and sleeplessness and fatigue. The individual may be frightened either through threats or by injury into admission of actions or he may be taken to the scene of a crime, or shown objects related to it in order to break his "resistance." Although such methods do bring admissions of actions, courts may refuse to recognize them. In an arson case, for example, where a statement was obtained from a feeble-minded person by telling him that the best thing to do was to own up, by giving him drinks, and by taking him handcuffed to a lawyer's office where he was examined behind locked doors by "hostile" persons, the court held that such a confession was not "voluntary." It said that "legally and morally a more serious offense was committed in the efforts to extort a statement than the person was guilty of, even if his confession was true, as it was a perversion of the process of the law—a poisoning of the fountains of justice." Despite all this, many cases still come to light in which methods close to the torture of the Inquisition of the Middle Ages are used.

Two cases of this sort occurring within the last two years can be cited. The one concerns a member of the Japanese House of Peers who drew from his personal experiences in bitterly attacking the government for allowing police to use "medieval" tortures to force confessions. A 72 year old man graphically described his torture for an alleged political crime. He then cited other cases in which police hung their victims by their heels, poured water down their nostrils, burned and flogged them unmercifully to force confessions to law violations. The other case is that of the father of Prof. F. Monaghan (Yale) who was recently carried dead from the Uniontown (Pa.) detective head-

quarters after being "questioned" in connection with the stabbing of a County Detective. An autopsy revealed that his injuries included 11 fractured ribs, a broken nose, hemorrhages and various cuts and bruises. Gov. George H. Earle called the case one of the "most brutal, horrible" events in the legal history of Pennsylvania.

2. *Experimental Methods*

From psychoanalysis have come the well-known association tests, and from the field of emotional experimentation have come what are commonly known as the expressive methods. The association tests tap an individual's stock of associations. He is given a number of stimulus words and is asked to respond to each as quickly as possible with the first associated word. Among the list are certain words that have no connection with a particular situation in terms of its objects and events. A record is kept of the time between stimulus-word and response. If the *critical* or significant words give a longer reaction time than the non-critical, or if the association response given is "meaningless"—boy and grass, axe and sky, or if the times are very short, guilty knowledge is indicated. The accompanying graphs (Fig. 5) show some reaction times for two subjects in terms of seconds taken for response. You can see that a few associations here give "trouble." The second group of experimental methods, which give data bearing upon past life situations, stress physiological changes directly resulting from psychological functions. The individual is tested both while reciting his story of a particular period and under cross-examination. Measures of his blood pressure, pulse rate and breathing rate (lie detector) are secured for specific items bearing upon his activities. These measures are compared for purposes of understanding with measures gotten for items *not* concerned with a particular situation.

Until recently, all attempts to use experimental methods in

determining "guilty" knowledge were generally frowned on. Legal thinking maintained that evidence (confessions) obtained by scientific methods, like those obtained by 'third-degree,' weakened the prosecution's case because of their illegality. This line of thinking doubted, for instance, that the lie-detector could *ever* legally be used with a criminal or that evidence (confessions) obtained by such methods could be admitted in evidence by American courts. A strong case exists, so they claimed, against the admissibility of all such evidence, for according to the Constitution of the United States, no person shall be required to appear as a witness against himself. Such a provision, we are told in part, "is also found in most state constitutions. There has not been much of a body of decisions built up on precisely what the meaning of this is, but Justice White in the case of *Bram versus the United States* declared with considerable clarity: In criminal trials in the courts of the United States wherever a question arises whether a confession is incompetent because not voluntary, the issue is controlled by that portion of the Fifth Amendment to the Constitution of the United States commanding that no person 'shall be compelled in any criminal case to be a witness against himself.' Clear as this language may sound there does appear to be a question as to whether it covers the inventions of science such as the lie-detector. Inasmuch as the respiratory and systolic reactions of the prisoner create the registry on the lie-detector it would seem that he is a witness against himself and an especially involuntary one in that, if the machines are in fact efficient, he cannot possibly conceal those reactions. There are decisions relating to the forcing of a prisoner to submit to tests of a nature which might tend to incriminate him, and, thereby, constructively, make him a witness against himself. Perhaps it may not be very widely realized that a prisoner whose footprints the police believe they have recognized at the scene of a crime, may not be required to place his

foot in those prints to establish identity. Court decisions have held against such a practice because this makes the prisoner a witness against himself."

This, however, is now changed. Two cases may be cited in this point. (I) In 1937, after being subjected to questioning for three and a half hours under the "lie detector," the parents of Roger Loomis, 5, murdered Lombard boy, were given a "clean bill of health" by authorities. At Northwestern University crime detection laboratory, where the tests were conducted, the state's attorney said: "The lie detector records indicate both persons are telling the truth. I am satisfied that we have nothing further to learn from them. Their stories were the same as those they told previously." The parents voluntarily submitted to the tests. "We want to co-operate in every way," they said, "we will do anything the authorities suggest and anything we can to solve this crime." (II) In 1937, a Wisconsin judge allowed data obtained through the lie detector to be admitted in evidence before a jury sitting in an attempted murder trial in which the defendants pleaded "not guilty." Two men, Grignano and Loniello, were charged with intent to murder a sheriff when he tried to stop their car. When the lie detector was strapped to the arm and chest of Loniello, and he was asked if he shot the sheriff, a wide fluctuation of the recording device accompanied his reply. His response to a query as to whether he was driving the car showed a very mild ("normal") fluctuation. Grignano's response to the shooting question showed a "normal" fluctuation; but when the one about driving the automobile was given, his response was violent. But to each question, the defendants replied in the negative. The jury, however, found both guilty. Following this verdict, the judge asked each juror as to value of the tests in reaching a decision. Each stated that they were of "considerable help" in determining the credibility of the defendants. "This is a signal victory for those who believe in scientific crime detec-

tion," the director of Northwestern University's Crime Detection Laboratory points out. "The findings of the lie detector are now as acceptable in court as is fingerprint testimony." Prior to this case, the attitude of courts toward this form of scientific method was identical with that earlier shown toward finger prints. It is indeed significant that for a long time, courts refused to recognize fingerprint testimony—there was no precedent; it had never been done. Even in 1941, the daily papers reported that when an attorney in a Chicago court demanded that a lie detector test be permitted, Judge Desort said, "With all this mechanical stuff, you don't need a judge. You might as well go before a robot for a machine-made decision!"

B. Inside the Courtroom

The Judge

A "complete" discussion of the psychological aspects of a judge would involve all problems of the human adult. He has his prejudices, his fond beliefs, his moods and his emotions. Although many laymen may hold that a judge is coldly impartial in court room procedure, prejudices always color his decisions. Quite frequently it is common knowledge among members of the bar that a judge is prejudiced in a certain direction. Thus before one judge it is impossible to have a will set aside for any cause, another judge may lean toward labor or capital in the struggle for economic leadership. Although the U. S. Supreme court now (1940) upholds minimum wage laws, it found them to be contrary to constitution in 1936 when it was claimed that such laws "violated freedom of women to contract to work at low wages." Justice Stone charged that the earlier verdict was governed by "personal economic predilections." But this was in direct conflict with Justice Roberts' assertion that the court merely lived up to the letter of the Constitution. Roberts did not say

that the "letter" depends upon the reader. Who sees—reads—the Constitution determines what is in it. When this relationship is widely understood, a new attitude toward all such matters will directly emerge.

1. Prejudice

At times, there is a widespread agreement among the people concerning the social and legal unfitness of a judge because of his strong prejudice. From a large field, former President Hoover picked and named a man as successor to the late Justice Sanford. But he failed to secure the approval of him by Congress because of its opposition to his prejudicial attitude toward an industrial class and a whole race of people. When Woodrow Wilson submitted Brandeis' name to the Senate for the Supreme Court, clubs were formed over the country, lobbyists worked strongly upon members of Congress, and former president Taft, later to preside over the Supreme Court, publicly attacked Brandeis. Seven former *American Bar Association* presidents condemned him at Senate hearings, which lasted *five months*. The major arguments were that he was "not temperamentally fitted" to be a Supreme court justice; that he was a very dangerous "liberal" or "radical" who was opposed to private property, the profit motive, and large accumulations of wealth. But he was finally selected, despite great pressure by conservative groups, and went on to win "recognition as one of the greatest figures in the history of American jurisprudence even by those who disagreed with his stand on economic and social questions. The results of his thinking have become so thoroughly imbedded in the court that they will influence the trend of decisions for many years." A conflict between the President and the Supreme court arose in part as a result of a judicial usurpation of powers which for years has simply enabled the Supreme court, subject to no restraints other than those of its thinking, to substitute its own

individual views concerning necessary legislation for those of a Congress directly elected by the people. Justice Holmes long ago warned the court against so hazardous an adventure, and openly but unsuccessfully fought other justices on this matter. The political, social and economic prejudices of a long-held majority blinded them to the needs of a new age. "It is socially undesirable," an authority writes, "that a court should be able to delay necessary federal activities for a period sometimes extending over many years."

American judges are always selected in part by reason of their attitudes. Before he appointed Holmes to the Supreme court, Theodore Roosevelt took great care to satisfy himself that the judge's views of the limits of federal power harmonized with his own. Since the Constitution legally is, as Justice Hughes once remarked, what the judges say it is, it is expected that a President will pick men whose attitudes resemble his own. And, since Judges, like other men, find it extremely difficult to change, there is constant need for younger men with new patterns, attitudes and approaches. A liberal English writer remarks that, for a long time, decisions in our courts have been literally unintelligible except upon the assumption that the Constitution intended that judges permanently safeguard unchanged the rights of property or wealth as these were earlier understood in an age when individualism was rampant. The U. S. Supreme court has, by a majority, chosen to adopt a political attitude whose major premise is the protection of capitalism from any control by the federal government. A liberal holds that such a conception of the judicial office is wholly at variance with the needs of the modern state. For many years, it has been difficult to distinguish the thinking of the Supreme Court from that of Wall Street (Laski).⁵

You can understand, therefore, that lawyers try to select those judges (where such selection is possible) with whose prejudices upon a particular point they are familiar; under such condi-

tions, they have a much better chance to win. "Many an industrious young attorney, who has been bitterly disappointed by a defeat in a legal controversy, later learns that the result was due to a prejudice to which he had given no attention whatever. He had proved his case, but it was decided against him. These uncertainties in the administration of justice cause much severe criticism. The fault rests in part in the law and in part in the frailties of human nature." At times a judge, realizing his prejudicial leaning and desiring to be impartial or wishing to avoid giving a decision that may be reversed by a higher court, may request another judge to serve. At other times, changes to another court are taken to permit trials under conditions in which other judicial prejudices operate. Outstanding factors producing prejudice in judges are involved in race, sex, fraternal (!) orders, labor, age, health, religion, sports, property and friends.

2. Question of Emotion

Of the relative roles of reason and emotion in judges, Arnold⁴ writes that "the existing ideal of a Judge appears to be that of a kind of abstract man, in whom all emotion is wanting and only intellect remains. Further, this intellect rests mainly on a knowledge of the textbooks and precedents of the law, and the power of drawing acute and fine distinctions which will serve to restrict the view to the narrow limits of such learning, prevent the mind straying into the broad paths of experience of life, and so attain certainty and uniformity in the law. This intellect is necessarily of an over-cautious type as it is bound down by rules which it must always be on the lookout not to transgress, and the compliance with which is, for it, the necessary condition of the existence of law as a Science: it is further divorced from emotion, which is the source of confidence, and utilizes whatever it finds ready to hand. This over-cautiousness is often intensified in England by the excessive age of the Judge and his consequent well-

known tendency to distrust new ideas and look only to the past for guidance. Lastly, this despising of emotion, reliance on intellect and ideal of uniformity and certainty, and the building up of science of law, leads the Judge to be satisfied if his decisions comply with abstract rules and an artificial procedure, and to be indifferent to the effect of his decisions on the litigants." We venture to uphold the view that the first object of the law should be to promote justice: the chief qualification for this on the part of the Judge is the ability to enter into the feelings of those who come before him. The meaning of life lies in the part which purpose or individualism plays in it, and the emotion which enters into it. Interest and passion obtain throughout and cannot be neglected. These can only be grasped by imagination without which a Judge cannot get at the truth of facts. Well do we know the case of the rustic witness who denies he knows anything for fear he may be brought to court and involved in trouble, but afterwards admits that he saw the whole occurrence. He as often as not is disbelieved by the Judge, who has not sufficient imagination to put himself in the place of this Burman agriculturist and finds it safer to discredit him on the ground that he has contradicted himself. The Judge who eviscerates all his emotions and applies strict rules of evidence to exclude much information which bears on the case may arrive at impartial decisions, but they are empty ones and often mistaken. We do not want then a Judge without feeling, but one who will enter into individual circumstances and consider them, and will not trust to general rules and award punishment according to normal scales. We do not want one who thinks he must put on a special judicial attitude when he goes on the bench and cast off all his humanity and ordinary ideas of life.

3. Sentences Passed by Judges

When not limited by legislation, judges differ markedly in the

sentences which they pronounce. While a particular sentence may possibly be mandatory, in many cases judges enjoy "legal freedom" in determining sentence. In 1935, a prominent judge wrote of this socially important topic that "the whole matter of sentences is fraught with incredible difficulty, incredible uncertainty, and will always be. For judges have no claim to omnipotent power to read the secrets of men's minds, of men's hearts. And without that power, none can say that a certain punishment will or will not reform the accused, will or will not, by the example furnished, deter others from like crimes. For the ages have produced no formula, no sure remedy—and all schools of legal thought and all systems of penology are harrowed and mocked by knowledge of calamitous failures. Common sense, intuition, experience in the world with people of all classes, are perhaps the best aids available, pitifully insufficient though they are, in getting at an approximate answer to an age old problem." In light of such statements, it is indeed significant that Illinois in 1941 faced a demand by judges that they be given an opportunity, taken away from them a few years, to make use again of "common sense and intuition" in determining the price to be paid for anti-social actions—how many years of life or how many dollars. All judges are neither unintelligent nor unaware of their limitations, neither dishonest nor indifferent to their social obligations. It is significant that few judges are ever found guilty in such respects. The case of Manton who was convicted in 1940 of giving decisions influenced by tremendous bribes was the first violation in a high court (next to Supreme Court) since Bacon in 1621. Manton's remarks at the time of being sentenced were peculiarly pointed: "A judge has been struck down by what is tantamount to a death sentence. It matters little what becomes of my poor body during the years I have left in life, but it matters what is done here in the name of the law, and how disgrace is visited upon a loyal judiciary *in the name of justice.*"

His thinking did not cause him to say that "honor, not disgrace," came to a judiciary loyal to its social obligations and not to individuals.

One striking feature of the psychology of judges concerns their tendencies to pronounce sentences in terms of certain lengths. The Director of the U. S. Bureau of Prisons remarked in 1934 upon the tremendously long sentences which our courts mete out to certain types of offenders. It has been said that courts attempt to strike a balance by lengthening the sentences of those we catch to produce a deterrent effect upon those whom we do not. In the last decade, not only have our legislatures increased the quantum of punishment for certain crimes, but courts and parole boards have been led to impose longer sentences. "In Auburn Prison there are two youths, ages 21 and 25, who are serving sentences of forty-seven years and six months (to life) for robbery. One of these will be 68 and the other 72 years of age when released. One man, 69 years of age, is serving a sentence of from fifteen to thirty years for robbery. He will be 84 years of age when released. "One effect of all this is to produce violent prison riots. A few years ago, at Columbus, Ohio, more than 300 men lost their lives in a riot. In Canyon City, Colo., convicts seized guards and a building. At Intervals, they murdered a guard and threw his body from the window into the courtyard below.

Data show that sentences are dependent in part upon (psychological) preferences of judges for particular numbers. Added years of detention in prison may result because judges prefer one or another figure. The two figures given here reveal some interesting data. The first, Fig. 6, shows the number of sentences and length in months and the other, Fig. 7, gives the number of sentences and length in years. While there are 300 sentences for a length of 18 months, not a single sentence is given for 17 months. Four times more sentences are given for a period of 5

years than a period of 4 years (not shown in chart). It is possibly significant that a recent investigating committee of the *American Bar Association* reports that judges are too frequently "carelessly lenient," "biased," "play hunches," and follow practices "deserving of censure" in disposing of criminal cases; that, on the whole, a very unscientific job of determining the treatment imposed upon those convicted of crime is being done by most judges; and, that criminal court judges need more specialized training in those sciences that are making significant contributions to the study of human behavior, if they are to exercise a dominant power in determining what treatment shall be given to persons convicted of crime."

4. The Jury

The juror shows the "individual" side of man's psychological make-up as well as those other sides which emerge only when in a group. Being in a group, a juror tends to be more emotional and think less (function intelligently and impartially). Like a judge each juror has his many individual prejudices, likes, dislikes and convictions, and his social cooperativeness and loyalty, his obstinacy and antagonism; but, unlike a judge each juror is not so specialized in legal matters as to crystallize his prejudices and formalize his thinking. His decisions are not cut-and-dried affairs as they are with many judges. He is more able to identify himself with the person on trial. He has more sympathy for the man and less veneration for the "technicalities and niceties" of the law. Since judges (by training) are strict legalists, jurors furnish a psychological balance wheel in the legal system, as it is now constituted. The jury has been greatly criticized—in fact, its abolition has been repeatedly advocated; but it possibly gives a current democratic touch to a system based upon a past that is often as outmoded as the "horse and buggy." Twelve men, drawn from various walks of life, give a more balanced pattern

in terms of differing prejudices and sympathies than can any one man. As the law continues to move away from the present system and toward the clinical approach to treatment of causes of actions in terms of their effects upon society, the need for such balancing will decline. When criminals are treated by the law after the manner in which patients are treated by doctors, the jury will have no social utility. In fact, it has no place in today's trials when scientists and doctors discuss matters which are closed systems to the educational training of the average juror.

The juror is not a scientific searcher for truth. His task is to reach a decision from the "evidence" offered to him by two groups of men, each striving to prove opposite ends. He is caught in a game of wits with a referee hedged on every side by traditions dear to the institution. All this contributes to bias. And, in addition, the juror himself must be given evidence without arousing his own personal antagonisms by running counter to his prejudices. Furthermore, for various reasons, he does not follow any closely knit chain of reasoning. He very definitely selects—takes some and rejects other materials. He acts towards evidence in a court room as a dyspeptic does toward food in a cafeteria. A little dressing goes a long way—prestige of witness or showmanship by lawyer causes him to accept certain materials which stay with him and affect the pattern which he creates when he retires "to reach a decision." Jurors, like most people, are not inclined to labor in thinking, when it is not demanded, so it is understandable that a jury comprised of farmers, laborers or business men is as capable of arriving at a verdict as is a group of professional men. By any criterion whatsoever, extensive training in professional lines does not in general produce "better" jurors. The same holds for different educational levels; persons with high school training are as efficient as are those with college training. You understand, of course, that to determine a "final"

truth is impossible; it is always relative to the individual.

Concerning the difficulties which judges, who exercise most important judicial duties, commonly encounter in arriving at the "truth" from a mass of material presented as evidence, a former Supreme Court Justice states that "an experience of twenty-five years on the bench, and an observation during that time of cases brought from all the courts of the United States to the Supreme Court for review, have satisfied me that, as a method of ascertaining the truth in regard to disputed questions of fact, a jury is in the main as valuable as an equal number of judges would be. And I must say that in my experience in the conference room of the Supreme Court of the United States (nine judges), I have been surprised to find how readily those judges come to an agreement upon questions of law, and how often they disagree in regard to questions of fact, which apparently are as clear as the law! I have noticed this so often and so much that I am willing to give the benefit of my observation of this subject to the public, that judges are not pre-eminently fitted over other men of good judgment to decide upon mere questions of disputed fact" (Miller).⁶

A decision in 1938, marking a very significant break with "truth" as measured by long established precedent or legal tradition, may possibly bear significance here. Two of the three judges of the United States Circuit Court held that federal judges have no right to comment to the jury on the merits of evidence. Such comment, the judges said, abridges the constitutional right of a defendant to a fair trial and invades the jury's province; it should be stopped. Such right of comment has been unquestioned in the Federal Courts since long before the Civil War. In this particular case breaking with the past, the judge had summed up the case for the jurors and commented upon the validity of the evidence presented in the court. But the high court ordered the case back to the district court for a new and

fairer trial. Judge Evans in commenting here called proper "the firmly established federal practice" of the judges in jury trials "analyzing factual controversy, dissecting the evidence and commenting on the case, when it is exercised only in exceptional cases, and where it is made clear that the court's *opinion* must give way to the jury's on matters of fact. In brief, the theory is that the jury has the benefit (!) of the light of a judicial lantern in its search for the truth (through a witness) but light must be used only to assist the jury in its search. To be helpful, the light should be illuminating, not blinding, dazzling or diverting." You can no doubt readily realize the ease or difficulty of determining when a light "illuminates" but does not "divert" a juror.

Judge Major pointed out in his opinion on the case that there is no question of the legal right of the trial judge to summarize the evidence on both sides. But the expression of an opinion by the trial judge on merits of the case and upon the issue which the jury is to determine is plainly an abridgment of that right (the sixth amendment to the constitution guaranteeing a speedy and public trial by an impartial jury) and the damage cannot be overcome by admonishing the jury that they are not bound by it; but, notwithstanding such opinion, it is their duty to form their own opinion from the facts and law in the case! "How any defendant could have a fair and impartial trial," he said, "after such proceedings is beyond my ability to comprehend. Under such circumstances the right of trial by jury becomes an idle and useless ceremony." Upon expressing by the court of its opinion as to the issue which the jury is to determine, the judicial lantern ceases to be such and immediately becomes a beacon light, so dazzling and blinding that there is little if any, opportunity for the jury to follow any road but that which is shown by this guiding light. I join the opinion of reversal for the reason that the remarks of the trial court were such, in my opinion, as to

preclude a fair and impartial trial, and yet to my mind such remarks were far less damaging than if the court had expressed an opinion that the defendants were guilty. It would seem paradoxical to preclude a court from making one-sided comment on the evidence and at the same time permit it to express an opinion upon what is fundamentally a jury question and which, from its very nature, could not be otherwise than 'one-sided.' The same condition applies to the lawyer. In a recent decision, Justice Roberts (Supreme Court) held that one of the most reprehensible things a prosecutor can do is to attempt to put into evidence before the jury his own, and his colleagues' opinion as to the guilt of the defendants he is prosecuting.

5. The Lawyer

Everything within the courtroom is done for the benefit of the jury. The witness slowly parades, the lawyer cleverly performs, the defendant sadly poses and the judge ponderously sits before it. Before an "important" trial, a lawyer strives to learn about the prejudices—economic, political, professional—of prospective jurors. If he is unable to secure jurors who are favorably prejudiced, a lawyer tries to see that they are neutral. Moreover, before trial, a possible witness may be visited. By flattering him in being the first to call, the lawyer may secure his cooperation, or he may cause him to commit himself to a position; to be on one side. Important witnesses may be trained in procedure before testifying to lessen possible emotional disturbances and to develop coherence in testimony to be given. That such coaching formalizes certain steps and increases effectiveness of the witness is evident; that it introduces other factors, desirable to one side, is less evident but quite significant in terms of the outcome.

Throughout a trial, a lawyer works upon the judge; he tries at times to intimidate him by hinting that, if he loses he will

appeal to a higher court for a possible reversal of the case with its attendant reflection upon the judge. He handles the witness to produce favorable testimony or to discredit him. He appeals by word, gesture, and posture to the jury. His posture and actions indicate his attitude on the case, and help to create the atmosphere which he desires for the trial. He pleads emotionally with them as kind parents, as loving sweethearts, as mighty captains of industry, or as plain persons of a particular class. He flatters their vanity; he arouses their prejudices; he appeals stirringly to their sense of duty. He paints vividly in imagination a picture of a desolated home, a bereaved wife, an aged mother, a fatherless child. He pictures the inexpressible longing of the sorrowing one—

For the touch of a vanished hand

And the sound of a voice that is still.

The use of this emotionality by a lawyer is revealed by the following plea of Walker (former Mayor of New York) for the release of Mooney. At the climax of his plea, Walker paused and looked intently for a moment at Mooney's aged mother who was present in the courtroom. Then he turned back and began to speak so softly that his voice barely could be heard. "This glorious sun will go down tonight," he whispered, "it will go down on many other days to come. But it will go down on one day when Mother Mooney will not be here and will not see her son." Raising his voice to full power, the mayor shouted: "O, God, don't let that happen. Don't do this unnatural thing and keep Mooney from being there." Thus, many lawyers use "tricks" which are usually theatrical, for particular occasions. You can understand, therefore, "the charges made by intelligent and articulate members of the public that the determination of controversies before a modern jury is very nearly as capricious as trial by ordeal. Trial lawyers often delight in regaling each other with their experiences with juries. Do they ever stop to wonder

what effect these capricious verdicts have on the minds of litigants and on observing members of the public?" (Harno).⁷

6. The Witness

Functionally speaking, the witness is a perceptual, memorial, imaginative, emotional and understanding creature. He remembers—sometimes too much, sometimes too little; he imagines, but often so much as to give testimony which has no perceptual foundation. His loyalty to one side biases him. Such often holds in the case of the expert witness who testifies for one side. Lawyers make capital of this possible condition; they try to cause a juror to believe that expert witnesses (who are paid) cannot possibly give impersonal evidence. In a recent murder trial, for instance, a ballistic expert, while discussing the relation between a gun and two fired bullets, was asked by the defendant lawyer concerning the amount of money he expected to receive for giving such evidence. Generally speaking, then, the conditions under which expert testimony is given must greatly change before society receives many results of scientific methods in the courtroom. The thinly-veiled hostility of many courts towards expert witness is well known. The specific reasons here are largely personal and traditional. He uses no "precedents"; as an expert he describes facts only (not opinions, inferences, or deductions). He deals with a phase of life quite strange to men whose whole lives concern the past—whose only aim is to discover what some particular judge, regardless of how many generations earlier, thought about a life situation. The following case may possibly illustrate this attitude. In a case of kleptomania, the judge in summing up the evidence of the witnesses said to the jury: "Medical men have been called as experts by the defendant, to give evidence as to the mental condition of the defendant at the time of the acts charged in the indictment. This evidence will be of greater or lesser aid to you in your delibera-

tions depending very much on the skill, knowledge, and experience of the witness, and his acquaintance with the subject under investigation. It will readily occur to you that this kind of evidence may be *quite reliable and satisfactory or the reverse, and entitled to little if any consideration*. It may be remarked, too, in regard to the evidence (which is made up largely of *mere theory and speculation* and which suggests mere possibilities), that it ought never be allowed to overcome *clear* and well established *facts*. In this connection, I deem it proper to say that while, perhaps, the profession of law has not fully kept pace with that of science on the subject of insanity, scientists have propounded doctrines respecting it as an *excuse for criminal acts* which a due regard for the safety of the community, and an *enlightened* public policy must prevent juries from adopting as part of the law of the land." The case was appealed. The Supreme Court reversed it and rebuked the trial judge and condemned his language.

Witnesses often draw upon their imagination in attempts to defend others as well as their own self-respect; they will even jeopardize their freedom and property through perjury to prevent acknowledging that they were previously wrong about a matter. There are "honest and well intentioned people," we are told, "who, when they go on the witness stand, unconsciously exaggerate one circumstance and minimize another. Under cross-examination they become antagonistic, throw truth to the winds and stick to any statement they have made without regard to its falsehood." You might remember this when you get on the stand: the most desirable witness has been described as a "quiet, tractable, conscientious, unimaginative person" who gives the information sought without attempting to display his knowledge. Finally, since many witnesses do not know the differences between fact and inference, or the difference between *opinion* and *fact*, they usually become emotional when the judge warns them merely to

state facts. Even college students, not to mention college professors, occasionally find it difficult to separate fact and fancy (phantasy).

In theory, the evidence given by witnesses constitutes the materials used by the jury in reaching its decision, presumably through thinking. Testimony has been widely studied by lawyer and by psychologist. The former has attacked the problems in terms of "what" evidence may be accepted and "how" it may be gotten before the jury. Thus, witnesses are not permitted directly to give inferences, hear-say or opinions because the juror tends to make them his own! The lawyer, of course, is limited by precedent in all his dealings with testimony. "The end of the lawyer's research," an outstanding authority points out, "for the most part is to find out what other lawyers and judges have said about the question under investigation. In searching for precedent the lawyer works diligently; he is discerning; he is ingenious and often brilliant in making close distinctions; he reasons well by analogy; but the ambit of his thinking is narrowly confined (Harno). The psychologist has attacked the problem experimentally. He recognizes that "testimony" is always a description of previously experienced objects given as they are recalled *in the court room*. The psychologist finds three major sets of conditions—"how factors"—affecting such reports. Each determines the reliability of the testimony. These factors are conditions at the time of perceptual experience, conditions of the interval between perception and recall, and conditions which operate at recall. Always an individual must first observe objects and then remember them. If he did not observe originally, or if he cannot remember later, he cannot serve as a witness.

7. Conditions of Perception

As a result of certain factors, most persons observe relatively little. Sense-organs may affect testimony. A near-sighted or color-

blind individual cannot report on the same meaningful characteristics of perceived objects as does one with greater degrees of perceptual ability. Since persons blind in one eye perceive the location of objects differently from those with two eyes, they may maintain that a car, for example, was in the clear in case of an accident. Concerning the significance of perception for court procedure, Osborn (*The Problem of Proof*)⁸ writes of tests made on perceptual abilities: "These tests were made with persons of normal intelligence and approximately of the same age. It was found that seeing ability ranged from one hundred per cent of accuracy in eight minutes and thirty-five seconds with one observer, to sixty-five percent of error on the same tests, in nine minutes and fifty-five seconds with another observer. It is easy to understand in what peril the interests of justice would be if that second observer, unconsciously half blind, was called upon in court of law to decide a delicate question appealing to the sense of sight." Another condition affecting report upon life situations concerns number of objects an individual can perceive at any given moment. The span of perception is more limited in some than in other persons. Where many things occur rapidly, a person may perhaps perceive only two or three objects or characteristics of objects, in terms of his reproduction at a later time in the court room. Such limitations operate at all times in life situations.

To be added to the above causal conditions is the selective influence (upon functioning) of factors which emerged earlier in one's life. One never escapes from his past; it always causes him to perceive selectively. Because of sources of satisfactions earlier discovered in connection with certain kinds of objects, one is never neutral in life situations. One accordingly observes—creates or abstracts—certain things only. The entomologist, the botanist and the artist who walk together across a meadow do not see the same things. A detective does not perceive a

"murder scene" as does an undertaker; each sees features or characteristics pertinent to his task. It is accordingly recognized that changes in observation come with individual training and with intent to reproduce perceived events at a later time. Laboratory experiments reveal that when subjects are repeatedly required to describe certain characteristics, the amount of their descriptive report increases; they see more. This does not imply that the limits of their perceptions are enlarged to include *more* of everything. It does imply that training is always selective specialization. Man misses that which has no concern with his needs. Thus you often hear individuals say, "I did not see or hear that—I was interested in what was going on over there." Thus knowledge affects ability to perceive selectively. One ignorant of machinery, does not see as does a skilled mechanic. The raw recruit does not experience the intricate maneuvers of an army as does the seasoned veteran.

Many men believe they perceive something when they only infer it. The seen movement of another's hand or head or eye is directly inferred as a signal. Thus, a student may be asked by his instructor "Did you have something you wished to say?" Too much of such inference *where there is reference to self* is abnormal—"persons are continually signalling." Other instances here concern the skilled juggler who must constantly take advantage of this tendency. The spiritualistic seance also capitalizes upon it—no one with psychological understanding ever accepts any statement of the average visitor at spiritualistic meetings. In the court room, a witness testifies that he saw the defendant chasing another. All he saw, perhaps, were two persons running.

Emotional factors also affect perceptual observation. The "excited" person may see very little when measured in terms of what is later reported. He may rush excitedly past *friends* at the time of a fire without seeing them. An undomesticated animal being chased by a dog may rush directly among human beings.

Enormous differences among spectators' descriptions of situations are to be related partly to emotional factors, as shown by a study of lawyers, psychiatrists and psychologists in which two persons rushed into their meeting, wrangled a moment and then rushed out. The chairman immediately called for a written account from each member. The results show that 13 of a total of 40 men reporting failed to report 5% (or more) of the events which occurred. In addition, many men described events which occurred only in their imagination. The following table gives some data here.

<i>Number of Men</i>	<i>Important Facts Omitted or Unreported</i>
1	20% and less
14	40% and less
12	50% and less
13	more than 50%

8. Conditions During Interval

An individual may earlier observe but be unable later to give reliable testimony because of losses through lapse of time. The interval exacts its penalty. Clear experiences dim with time; vivid yesterdays fade into gray tomorrows. With passing time, facts slip away and patterns disintegrate. Such effects come in part through retroactive inhibition. What one does immediately following observation affects his subsequent report. He may, for instance, either report less or he may put what he saw later into the earlier pattern. Persons repeatedly testify that they cannot recall because they were either greatly shocked, called away or forced to do something else immediately following observation of some event. They also report "something" as occurring earlier although, perceptually speaking, it occurred later. Persons report: "I did recall it as happening at the same time, but now I remember that it occurred later."

With the omission or elimination of items, their accounts are often unsatisfactory to individuals. But persons commonly desire them to be consistent and logical. Not infrequently items are inserted to increase coherence. While the frame-work of the original experience may remain intact, the filling may be imaginative. Or, the realization that some item was previously there but not recallable causes "something else" to be substituted for it. The substituted object is frequently picked up by hearing or by reading. But the individual takes it for his very own. "Even the repetition of the testimony by the same observer lowers its reliability. Experiments indicate that the second report is often less based on the memory of the experience than on a mixture of experience and first report. The additions in the first report are likely to be starting points for further changes. Continued pondering over some occurrence, or imagining what might have happened, accounts for some changes commonly found in recall. In this connection, a man writes that we think of what we wish had happened, of possible interpretations of actions, and some of us are unable to distinguish between things that happened and our thoughts about what might have occurred. Our wishes, hopes, and fears are the controlling factors. At times, this takes a form that may be called retroactive memory. Knowing what we ought to have done on a given occasion, we think the action into the memory series (Swift).⁹

Recalled patterns, then, change because objects are transposed in time or in space. No object may be omitted or substituted, but a perceptually first object may come last or *vice versa*. A certain man perceived a day after a crime, is reported as having been seen a day before the crime. Or, in memory, an object is moved spatially from one part of an earlier perceived situation to another part. A gun is moved from the kitchen to the parlor. Swift summarizes this matter in this way. "Actions are transposed, omitted and inserted in the series of events observed. The

attitude at the moment, personal bias, and suggestion are always exerting their influence. Statements are misunderstood, qualifying remarks pass unnoticed, opinions added and much is forgotten. The speaker is made to say what we think he should have said—what we would like to have had him say; and in this last, the personal attitude toward the one whom we are quoting or toward the whole situation, is a determining factor.”

9. Conditions at Time of Recall

The measure of every observation is “how much” an individual can reproduce about a situation. The *functional* test of observation and retention is recall. One may claim, of course, to be able both to see and to retain much, but if he cannot recall much, his claim lacks factual significance. The concern of the court is with amount and order (in time and place) of things recalled. Memorial description always depends upon conditions inside and outside the organism during the original experience and during the interval. But it also depends upon the conditions present at the moment of recall. In the court room the excited (emotional) state of the witness due to unfamiliarity with its procedure is one such condition. Moreover, one wishes to maintain his self-respect as a credible witness; he is unwilling to make a “poor showing.” If he should come to believe that something has happened, it should seem that he is “expected” to have seen it, and if he should feel that not to have seen “reflects” upon his abilities, he tends to include it in his account. Then, if it can be shown not to have been there, he may stick doggedly to his original account in order not to lose prestige. Even the novelty of being questioned by strange lawyers often disturbs witnesses.

In addition, the questions asked him affect the reliability of his evidence. Whether his descriptive report is given in narrative form or only under interrogation is also important. While

questioning may double the range of recallable details, their accuracy decreases. Questions often lead to an elaboration which may not be based on perception. The narrative form, however, gives fewer facts but greater accuracy. High reliability comes with one form of question, low reliability with another form. If a lawyer desires to disparage a witness (and the judge permits) he uses certain questions which "tie the witness in a knot." Although the witness may strive to prevent it, the lawyer may repeatedly cause him to contradict himself.

In an experimental study of the effects of different kinds of questions, motion picture scenes were observed by 56 subjects, who were then questioned. Questions using the definite (the) and the indefinite (a) articles with the negative (not) were used. If we were to formulate illustrative questions, they might run as follows: "Did you see *a* body?" "Did you see *the* body?" "Was there *a* body in the car?" "*Wasn't* there *a* body in the car?" Another form of question was the "or" type: "Was the body in the car that of a young *or* a very old man?" According to this question, the body must be either young or old; but, of course, it might be neither. Finally, there is the implicative type: "What kind of hat was that woman in the car wearing?" This means that (1) there was a car, and (2) a woman who wore (3) a hat. But there may *not* have been any car, woman or hat. The results of such studies indicate that changing the indefinite (a) into the definite (the) article in a question decreases caution and reliability. Putting a negative into a question increases suggestiveness and decreases caution and reliability. When the definite article and a negative (e.g., *not . . . the*) were both used, suggestibility was decreased but caution and reliability were increased. The implicative form gave the lowest results for suggestiveness, caution and reliability. The "or" produces relatively high suggestiveness, relatively low caution and relatively

low reliability. The most reliable form of question contains neither a negative nor a definite article (Muscio).¹⁰

IV. Problems of Responsibility

A. From the Standpoint of Law

Intelligent treatment directed at desired social and personal ends to be reached rests upon the position taken toward problems of responsibility. The need for an intelligent approach is being more increasingly emphasized. In 1937, an authority in this field indicated the need for delving deeply into the basis of criminal law. The social engineer, he said, must study the concept of criminal responsibility on which the criminal law is founded, and which in one of its phases has given rise to a penal system which is 'as irrational in its mercies as in its rigor, and in its rigors as in its mercies' " (Harno).⁷ A final answer to the question, "Whom ought society to punish?" is impossible to give. It bears directly upon human intention, motivation, and understanding. No one can legally be held responsible if his intentions are opposed to committing some act. An individual forced through threats to his safety or security is not guilty of anti-social actions. To be related here are all accidental actions—those over which an individual has no control (unless he fails to provide reasonable precautionary measures). Intention to act results from *motive*. Intent is directive aim; motive is push or "reason." One is always conversant with his intentions; but motives, as causes, do not "lie on the surface." In a great many cases, they are unknown. One can say that he likes or dislikes to act without being able to say "why." A kleptomaniac can intend to take some object without an understanding of his motive. You can intend to secure a college education, yet have no understanding of your motive.

For all crimes, except those of omission, intention is necessary. But questions of motives may never be raised. It is ac-

cordingly stated that "when a crime is committed, the question of motive may be of little or no importance. But criminal intent is always essential to commission of crime." Pollock¹¹ points out that (with exceptions) action (not otherwise unlawful) is not illegal because it is done from a harmful motive, nor is it any excuse for an unlawful act, to show that its motive was good. But there is a growing tendency to lay greater stress upon motives as well as other psychological factors. Concerning motives, Dean Ames states that in certain cases, "willfully to damage another from a spirit of malevolence is wrong even though the same act, induced by a rightful motive, would be lawful." Justice Holmes said many years ago: "The law is made to govern men through their motives, and it must, therefore, take their mental constitution into account."

In this connection, Harno⁷ recently wrote that "we must give weight to a factor in the study of behavior which the law has long neglected, and not only neglected but consistently and expressly shunted aside. In order to interpret particular individual conduct we must have knowledge of the motives underlying the given act. It is a curious comment on legal learning that judges and lawmakers have so long resisted consideration of what is essentially the determining factor in human behavior—that they have taken the position that motive is of no consequence in the criminal law. Actually this element has slipped in, often vicariously when it was called something else, and at times *sub rosa* when it is often said that something made the jury go awry; but never has it received the august approval of the law." Increased emphasis on motives causes spite fences or unsightly structures to be viewed in a different way in recent years. The causal factors involved in self-protection constitute a class of legally recognized motives. The significance of motives is also shown in psychopathic cases. One who *intentionally* injures while under delusions is not responsible. All states now have laws to the

effect that an act done by a person in a "state of insanity" cannot be punished as an offense.

Courts ask if one intends, if one knows right from wrong, and if one acts freely. If he does (can), he is legally responsible. There is no question of social dangerousness here. The emphasis is simply upon the metaphysical problem of moral responsibility. Some courts cannot grant that an individual may know that action is wrong and intend to do it and yet be *forced*—not "free" to do anything else. They cannot understand "compulsions" as found in the forced behavior of phobiacs. Neither can they understand that *major crimes* have essential characteristics of the kleptomaniac compulsion; that an individual may know the difference between "right and wrong" and yet be unable to avoid anti-social acts. Yet changes are gradually emerging; thinking is being done in terms of modern knowledge. In a recent case in New Hampshire, the judge said: "whether or not any alleged criminal act is the outgrowth of mental disease is a question, not of law but of fact for the jury. We have consented to receive those facts (of science) as developed and ascertained by the researches and observation of our own day, instead of adhering blindly to dogmas which were accepted and promulgated as principles of law fifty or one hundred years ago." In Connecticut, a judge in considering insanity as determining the degree of crime said: "the evidence may fall far short of proving irresponsibility and still satisfy the jury that the prisoner ought not to suffer the penalty of his crime."

Washington earlier passed a law providing "that the determination of sanity be taken out of the hands of the jury, and that the judge should be allowed to commit the insane or the feeble-minded defendant to a mental hospital after the jury had determined that the act alleged had been committed by the defendant." But the law was declared unconstitutional on the ground that intent being necessary under the common law, as an element

of crime, the defendant had a right to jury trial. And, in 1928, Louisiana attempted "to confer upon a lunacy commission the power to determine whether the accused was insane, withdrawing from the courts the power to determine the present sanity of the accused and withdrawing from the accused the right to urge 'insanity' as a defense." It was declared unconstitutional on the theory that the accused had a right to a jury trial. In Nebraska, when the defense pleads "insanity," and the jury finds "not guilty" on that basis, it must so state in its verdict. "The court must thereupon order the defendant to be committed to the state hospital for the insane until he becomes sane and is discharged by due process of law.

Where the defendant is found to be pathological at the time he committed the act but later becomes sane, his pathology relieves him from criminal responsibility; and the fact that he is now sane takes away all grounds for committing him "to an institution." If the defendant was normal at the commission of the act but is pathological at the trial or just before execution, the judge suspends execution which will take place as soon as he becomes normal.

In Colorado, when insanity is pleaded the court must commit the defendant to a state hospital for a period of observation and study. This procedure is unique in that such commitment is compulsory upon the court, once the plea of insanity is made. In Massachusetts, under the Briggs Law, "all persons indicted for a capital offense and all persons who have previously been indicted for an offense more than once shall be reported to the department of Mental Diseases for examination. If a defendant is found to be suffering from a mental disorder, he is promptly committed to a mental hospital, where he is kept until such time as he may be tried." This statute, perhaps more than any other in America contributes to a closer union of law and science. As an instance of the working of this law, the following case is

cited. A brilliant young physician killed his brother-in-law because "God told him to do it." He was sent to the State Department of mental diseases, where he was examined and pronounced psychopathic. The state's attorney said that it is "not my duty to prove any innocent man guilty nor yet to prove that an insane man is sane. Rather it is my duty to lay before the Court and the jury all the facts of the case and to bring out the truth. In view of the facts I cannot conscientiously argue that the defendant is sane and if the Court directs a verdict of insanity I shall not oppose it." The Court approved and the defendant was sent to the State Hospital for Criminal Insane for life. This resulted in saving the costs of a trial; in avoiding a man's life being made the stake of a game of wits between lawyers; and in treating a human being in a way wholly in keeping with the modern concepts of scientific jurisprudence which is more concerned with the individual than with his crime.

B. From the Standpoint of Psychology

Law differs strikingly from psychology on problems of responsibility. Since law holds that certain criminals are "free" to choose, it follows that, if they merely want to, they *can* refrain from anti-social actions. Because they do not restrain themselves, it is "logical, just and necessary to punish them." But laws which go back to an outworn Blackstonian understanding of human nature conflict with modern scientific information and thinking.

The psychologist holds that man's actions result from causal factors in his heredity, his environment and his history. Man thinks about some objects rather than others and imagines certain satisfactions rather than others because he is innately endowed with certain functional abilities, needs and desires in connection with which he has discovered satisfaction. The psychologist points to reflexive, instinctive, habituated and psycho-

pathic activities as illustrative of what an individual does because of his past. He finds no "reason" in such cases for granting freedom to act in any way independent of previous causal events. In terms of causation, the individual acts because he cannot do otherwise; and he cannot do otherwise because of the contributions of his heredity and during his own personal history. Desires and associations of a particular sort cause certain actions. The individual is forced by needs which emerge at any given moment and by environmental circumstances to act in a given manner. He is not "free" to do anything else. A metaphysical "freedom of will" has no place in science; "willing to act like other phenomena" is determined by antecedent factors beyond individual control so far as these concern wishing or wanting. The old saying "if wishes were horses, beggars would ride" applies here. Let the student wish—will—to produce today a great invention, compose an oratorio, write a new chemical formula, get a new idea, run as fast as Nurmi, play pool like Hoppe, have no hunger for food or think the answer to a question on an examination. Let him consider his own life when he is in great pain, when deeply in love, when terribly afraid. Let him finally realize that differences between "insanity" and "normality" are matters only of too much or too little. He may then understand that responsibility, judged in terms of liability to suffering in retribution for action, finds no scientific bases in either sane or insane persons.

The criminal has a history different from that of many others and his conduct results in part as much from his history as worshipful conduct does from the history of a monk. If a criminal is "short" or "long" in intelligence or emotion, he cannot be expected to act as do those who are "mediocre." Or, some relatively strong set of environmental circumstances (physical, chemical) produce pain and anguish and cause action. In every case, an individual always does "the best he can" under existing

causal conditions. The law holds that the criminal must be mistreated to prevent him or others from doing "mischief." Psychology, holding to causation, stresses treatment based upon understanding of causes. If *causers* can be controlled, the *effects* (criminal conduct) can also be controlled. Since causes producing anti-social action vary, so treatment aimed at control also varies. You know that causes may be removed at times by removing an individual from a set of conditions (temptation). The feeble-minded placed in the country, the man removed from his gang, the love-sick girl sent to visit relatives and the student denied coke dates—all these and others show that causes may be controlled. Science finds that life-long removal through a protective institution is demanded in some cases. But the fact that, *in most cases*, only one court conviction is ever marked against an individual, is evidence of another kind of removal of causes. The psychologist maintains that intelligent treatment, but not punishment; sympathetic understanding, but not emotional condemnation are demanded as much with criminals as with medical patients. It is significant that medicine finally has reached a place where causes only are considered. It has thrown off the shackles of "black magic." But the law still carries a burden here.

When they think scientifically, society and its courts will realize that individuals do not freely choose criminal careers; they will recognize that behavior is determined by antecedent conditions. With this recognition, they will make an intelligent attempt to understand and to control the conditions which contribute to criminality. The following opinion of the Iowa Supreme Court on a woman who murdered her husband is significant here: "Outrageous and hideous crimes are often committed. Sometimes it is difficult for humanity to understand why sane men will perform these acts. Certain psychologists and medical experts believe that no mentally balanced man can be guilty of such

atrocities; yet, in the application of criminal law, it is necessary for courts to adhere to human experiences and the consensus of opinion drawn therefrom. Until more scientific methods are legally devised, this must be the policy of criminal jurisprudence" (McCarty).³

V. Ends or Goals of Treatment

A crime is held by society to demand institutional punishment. The nature of the punishment is determined by ends to be gained. Generally speaking, ends must concern both society and individual. Specifically viewed, there can be but one end, namely, protection of society which must always be gained by treatment of particular individuals. All men agree upon these two points. But they disagree greatly upon the treatment and "what" is to be treated—the crime or the criminal. The following discussion is to be understood in terms of this end and in light of the *assumption* that punishment effectively reduces crime. Current positions concerning the ends to be reached through punishment can be reduced to three: namely, retributive, deterrent and reformatory. The following statement illustrates a form of thinking about the treatment of criminals which touches all three of these ends. The integrative thread here is spun largely from free-will and common sense. There is no hint at other causes—mental deficiency, poverty, frustration, injustice (failure of law) and social indifference (parent, school, church). It might well have been written generations ago. "A new wave of resentment against the pampering of convicted criminals is sweeping over the country. Charges are made and reiterated in one section of the country, and then another, that convicted criminals are being given more liberty than they deserve; that they are better cared for than the honest people out of work; that they lead a less strenuous life than does the average citizen; and that so-called reformation of criminals is a huge joke. It may be that this wave

of resentment is finding an outlet in the various lynchings that are reported from one end of the country to the other. It may be that the numerous shocking crimes that are reported from day to day have a background in the fact that prisons have lost their terror. At one time prisons were thought of only as a place for the punishment of those who had broken the laws of society. Men sent to prison were punished there. They were made to perform back-breaking work. They were confined in close quarters that lacked sanitation. They were places of both physical and mental punishment. No doubt many of them were unfit for human beings. They caused physical and mental breakdowns, and unfitted their occupants for a return to society. Reformers took matters in hand and proceeded to bring about many changes in prison management and prison system. Many of the changes were desirable, as measured by humanitarian standards. But, like so many other reforms, theories were carried to extremes. The pendulum has swung too far in the opposite direction.

"In place of the old prisons that lacked conveniences, there have sprung up prisons that contain all conveniences; in addition, many of them have what an honest, hard-working family would consider to be luxuries. There are many, many homes without a radio, yet prisons throughout the country are equipped with the instruments for the entertainment of the prisoners—not as an educational asset. There are sanitary conveniences not possessed by hundreds of thousands of people who work and pay for what they do have. Opportunities are offered for recreation that would appeal to those on the outside. All of this is done with the idea of reforming the criminal—of changing his view of life, and making him desire to live a just and upright life upon his release. And all of it is done at the expense of those who do not have criminal instincts. The man who comes out of prison should have no malice against society that placed him there. He should be treated as a human being while in prison,

so that when he does get out, he will still be a human being, and not a brute. But when he comes out, he should look back on an experience that would prevent him from caring little whether he goes back. He should look back over an experience that would cause him to counsel others to keep on the straight and narrow path so that they would not be subjected to the experiences through which he has passed. When criminals are sent to prison, they should be sent there with the idea in mind that they are criminals. It should be borne in mind that few men go to prison who could not have remained out had they made use of their common sense. Crimes for which most criminals are convicted are planned crimes. Those who commit crimes carrying a prison sentence plan their crimes and plan to cover up their tracks. When they are caught, they resort to every device to escape conviction. Under such conditions, they are deserving of treatment that will cause them to reflect on the error of their ways. If it is possible to revamp the mental attitude of a criminal, every effort should be made to do so. But to treat the criminal as if he has been the victim of society is not the proper course. There is no need for physical punishment in prison, but there is a need for mental punishment. The criminal must be made to realize that he has violated the laws of society, and that organized society will not tolerate such action. He must come out of prison imbued with a desire to stay out by leading an honest life, instead of by resorting to the loopholes of the law. There is no reason why criminals should fare better than the aged and unfortunate who occupy our institutions for paupers, yet such is a condition that exists in every state. When we cease to pamper criminals, we will make crime less attractive" (Chi. Trib.).

Under retributive punishment, the criminal who has willfully injured, must in turn be injured. This position holds that society should bend every effort toward increasing its number of executions, making greater use of dungeons, intensifying its floggings

and giving life imprisonment to all criminals. It is significant that persons of high intelligence hold that the effective way to turn people from crime is to subject them to years of monotony and repression under pain and fear induced through harsh punishment. This very old "law" of an "eye for an eye" which expresses an intent to wreak vengeance still lingers in today's criminal code. Society has not evolved psychologically to the level where it no longer demands harsh punishment. Retribution is an integral part of social living. "The thirst for vengeance is a very real one, even if it be a hideous, thing" (Cardozo).¹² Illustrations of this statement occur on every hand. Recently two men accused of murder were lynched in California. The mob stripped them of their clothing and mutilated them. As they swung naked in the air, a large crowd including many girls and women surged around them, screaming, cursing and striking them.

Such punishment reaches back into the dim ages of man's history. All punishment grew out of such sadistic pleasures. Society did not move in until the Mosaic Laws and then it merely sought to prevent the individual from taking too much vengeance. There was no attempt by society at punishment of the injurious individual. In 600 B.C., society took a second major step. It removed punishment from the hands of the individual (family) to the state. Society now did the "revenging" instead of the injured individual or his family.

In 1937, Warden Johnston indicated in an interview that the federal prison on Alcatraz island is an institution of punishment, not of reformation. The main job is to impress on men's minds a life-long lesson of the power of the United States government and a realization that they are not greater than the constituted authorities. "We get the super-criminal, or at least those with super-ego, and our job is to deflate that ego," he explained. "We play them down, not up. We have had some tough customers, but I believe we have whittled them down to their proper size.

We have brought all of them to the realization that they are not as big as they thought they were." The prison has a director of education, but no study classes as are conducted in other prisons. The inmates are never permitted to forget that Alcatraz is a prison of punishment and not of reformation. Spirit is one thing that Alcatraz seeks to eliminate. Outstanding performance in competition might lead to a resumption of the egotism which the prison guards have taken pains to deflate. There is no commissary. The privilege of buying tobacco and the little extras such as is enjoyed in other prisons does not exist.

To evade admitting the retributive end, some men rationalize: they talk of upholding the majesty of the law and of maintaining the supremacy of society. To this end, we owe the determinate sentence which releases an offender at the end of a fixed term, irrespective of the effects of his sentence upon him. Likewise, the custom of dealing with offenders such as "prostitutes" by fines, mingled with short jail sentences, can only be explained in the same way. During the feudal system, a third major step was taken. Punishment was now inflicted in order to deter.

Under the deterrent approach, which is, perhaps, the most commonly admitted end, society today holds that in teaching a criminal a lesson, other persons who might be similarly inclined are restrained. The example of the punished one is assumed to be effective with the many; they are brought to a clearer realization of the penalty exacted for anti-social actions by appealing to their understanding and imagination. Individuals do desire, of course, to escape pain and suffering; but they also desire satisfaction of basic needs. You know that action is always directed toward satisfaction. You understand here, then, that *whatever* offers greater satisfaction necessarily serves as a determiner of action. To the extent to which appeals to fear may possibly be augmented by knowledge of the price to be paid, punishment may serve as a deterrent. Since other causal factors are always

involved in functioning, little gain ever results from such punishment. Radios, motion pictures and daily newspapers are found in many prisons. But they violate the basic assumption underlying penal systems throughout the world, namely, that the deprivation of freedom and isolation from the outside world are the chief ingredients of punishment. If deprivation of freedom in prison acts as a deterrent from further criminal activity upon release, then radios, motion pictures and daily papers can find no place in our prisons. But society is gradually changing in part under increased understanding of human psychology. A generation ago persons were publicly executed or whipped often before large crowds. Often, they were kept exposed to the public for some time. This has all changed. It is now realized that such treatment significantly affects society but not in the way it desires. You may be interested in a comment here by Harno.¹³ "In the light of long experience with penalties of varying degrees of severity, we can be fairly certain that the doctrine of deterrence cannot be made the central theme of a modern code. While it probably is true that there are inhibitions in the threat of punishment that society cannot afford to withdraw from any persons capable of feeling them, the fact remains that punishment as a means of control has been tried in a major role for centuries and has proved patently inadequate. Punishment for the sake of deterrence has been one of the theories, if not the major one, underlying criminal law administration during modern civilization; yet under its sway we have merely achieved a crime situation from which we ardently seek relief." From time to time, riots occur in prisons. Sometimes, hundreds are killed. Bates remarks that "one would think that the publicity of these riots would be clear to the prisoners. The fact that this is not the case is evidence of the intensity of the motives behind them" and the ineffectiveness of deterrent methods.

Foresight of certain consequences will not restrain when strong

passions work. Sexual delinquency, for instance, with its threat of life disgrace is all too well known to need discussion. Under great emotional excitement individuals behave in ways which they may unquestionably regret later. The world is filled with intelligent human creatures, who are constantly in the condition of "normal" man momentarily placed under tremendous stress, and with dull persons unable to realize little more than their urgent needs at the moment. These cannot be deterred by the most terrible penalties. "Imprisonment, hanging, electrocution, disembowment, all the horror which diseased imaginations of the centuries have been able to devise have signally failed to restrain men from criminal courses. Every page of history makes it clear that fear and terrorism are useless." Today, men get drunk though they *know* drunkenness entails personal suffering and social disgrace. Medical men *know* the personal and social consequences of drugs, yet doctors, as a professional group, are most addicted to narcotics. The thief sentenced a dozen times steals again as soon as freed. Since hopes of "eternal happiness" and terror of eternal damnation have so signally failed through the ages to make human beings act in ways society desires, it would be strange if mere threats and reproofs succeeded. In short, there are many who may be greatly afraid, yet act. In these cases, impulses are insistent, and intellect plays no part. When deterrent punishment fails in all such cases, it is more disastrous than either of the other two forms. In fact, retributive punishment cannot fail. When deterrent punishment fails in prevention, it does only harm.

The reformation of an anti-social person is the most recently formulated and aims at providing the greatest security for society. This end clearly emerged during the 18th Century as a part of the broad theory of expiation. Later, the emphasis shifted to education as a means of changing—reforming—the individual. The criminal is considered to suffer with a "disease of a

social nature." The primary object of punishment, then, is to cure the individual, thus indirectly protecting society. "If the former succeeds," we are told, "the second follows; whereas if the order be reversed, as now, there will always be failure in both objectives. To protect the community without reforming the culprit is impossible" (Wilson).¹⁴ Cure consists in re-equipping him with a new attitude toward society and with a new set of motives to sustain him in future social relations. He is rehabilitated or rebuilt functionally to meet society in a socially desirable manner. Reformation proceeds in part by increasing his industrial self-sufficiency through teaching him a trade which he can use when released. Studies show that few boys coming out of reformatories follow the trade taught in prison. Some claim they did not learn it well enough to follow; others say they could not get jobs at the time.

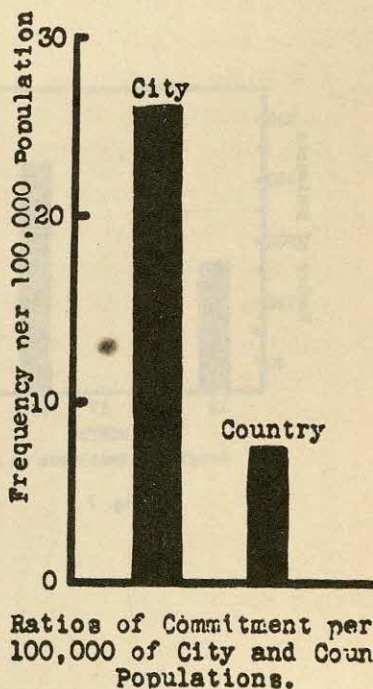
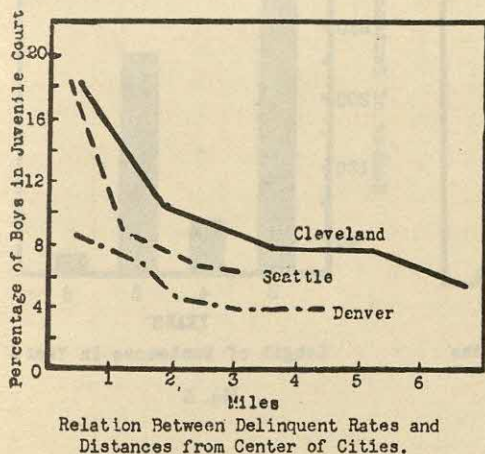
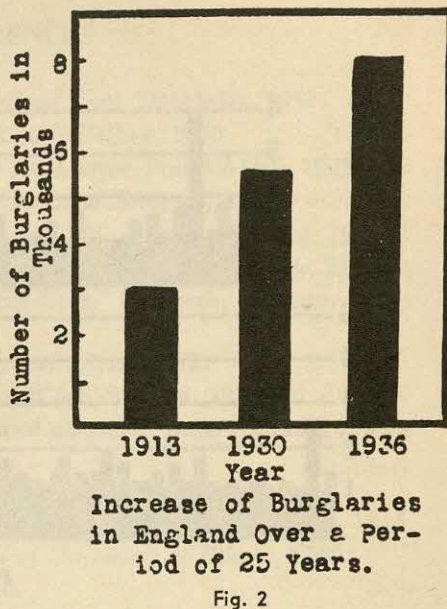
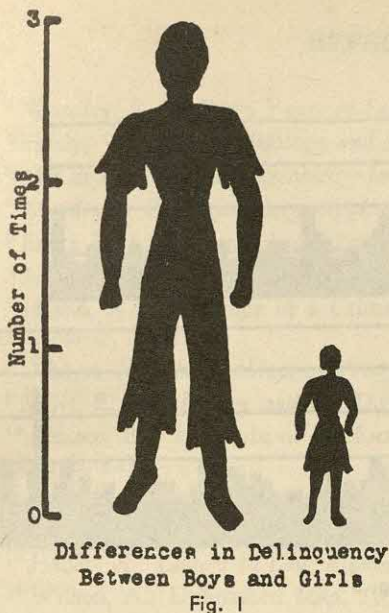
Much time and effort have been spent in this direction with possibly discouraging returns. Perhaps, this is due partly to methods. Little has been done to determine the conditions which lead to anti-social actions. Society must learn more about conditions which lead individuals into criminal careers before it can hope to understand and to deal effectively with them. This involves scientific investigation of causal conditions with a view to understanding them. Among other factors, are the benefits resulting from confinement in institutions. An Illinois judge recently remarked in this connection that all that can be expected from any penal legislation is to reduce the volume of crime to a minimum. But penal data show that this is not always accomplished by incarceration. In fact, incarceration is often responsible for an increase in crime. The object of legislation should be to keep the anti-social individual confined only so long as necessary for the welfare of society and to release him as soon as this can safely be done" (Fischer). Studies must show the extent of socially beneficial and harmful changes induced in in-

stitutions. In a study of 500 reformatory careers, 68% of the freed delinquents claimed that they had benefited from their stay in the institution, but 32% claimed no beneficial result, of which 27% said they had obtained further schooling in crime. To proceed intelligently here, one needs to understand how many of these 500 needed no such confinement at all in order not to violate society's codes; or, how many of the 32% were adversely affected by such punishment. You may find a statement by Harno¹³ significant here: "No one can review the histories of our prison population, which record how prisoner after prisoner has started a criminal career with juvenile delinquencies and petty offenses and has moved on through more serious crimes for which he has incurred sentences to reform schools and a series of sentences to penitentiaries, without being struck with the social waste, the futility, and the hopelessness of our processes. We would like to assume that these processes are aimed to protect society from anti-social elements. The discriminating observer cannot escape the truth, however that these procedures do not function in that way; rather do they increase the hazards of society through making those of its members who have demonstrated anti-social tendencies incurably and viciously anti-social. The modern state, it seems prefers to eliminate its weeds through an elaborate and costly scheme of watering and fertilization."

Society punishes many offenses by fines, where reformation is not even assumed to enter. Thus traffic offenses are treated. A more effective method would remove causes by revoking licenses. It has also been claimed that an offender should be punished for the "good" of society. If punishment results in the good of society, if society gains by punishment of offenders, this argument would be unanswerable. But many able men doubt that society benefits through punishment. If an individual is not changed by punishment, and if society does not gain, the sum total is a loss. Society has long been saying that it is necessary

to punish, but it has made few studies as to the basis of the process or the results secured from it. But evidence suggests that society is gradually demanding the extension of intelligent and impersonal methods to its many problems of social conflicts.

We have reviewed some psychological problems and methods of law. We considered judge, lawyer, juror, witness, and criminal. We find that the psychologist does not view matters as does the lawyer. The former believes that criminals are deserving of intelligent understanding; the latter holds that, under certain conditions, they must be punished. It is impossible to treat delinquents intelligently without an understanding of their psychological make-up. The court in which he is sentenced and the penal institution to which the criminal goes must be aided by the clinic. In the clinic, an understanding of his intelligence, emotional equipment and possibilities for desirable change may be secured. Only where information of this sort is available can a sensible program for criminal treatment be worked out. Of this point, the Committee on the Legal Aspects of Psychiatry reports that "only by recognition of the motives behind criminal conduct can the treatment prescribed by the judge be intelligently calculated to protect society and rehabilitate the criminal (if possible) at the same time. Moreover, only through the aid of trained psychiatrists, assisted by psychologists and sociologists, can those forward-looking methods in the administration of criminal justice, such as probation, the indeterminate sentence, or parole, be effectively administered."



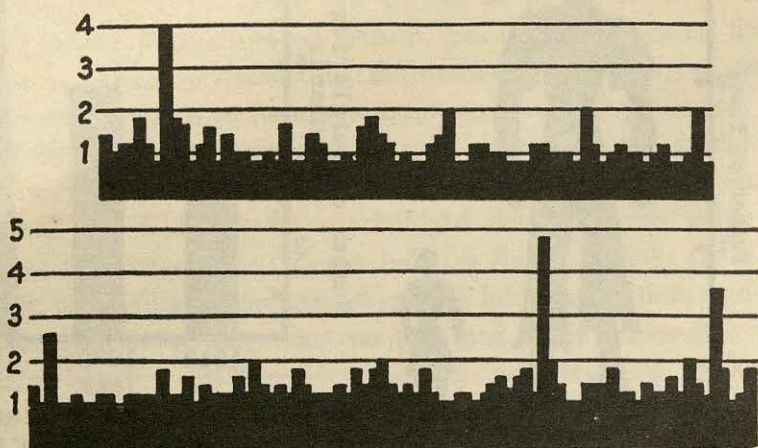


Fig. 5

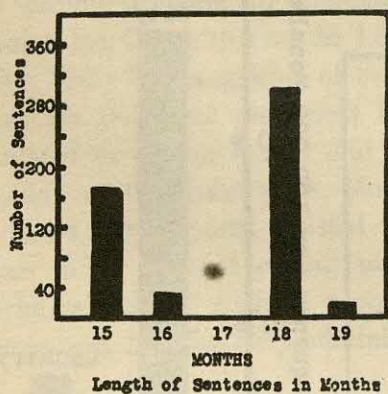


Fig. 7

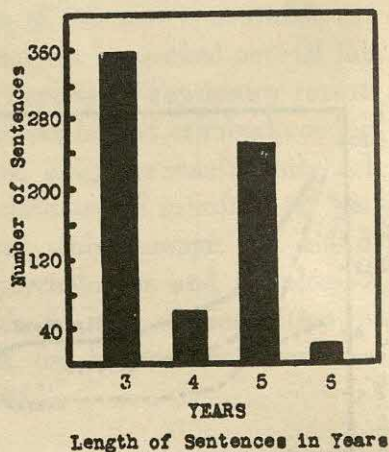


Fig. 6

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CONCEPTS OF THE UNCONSCIOUS

By

HARRIET P. RAY, M.A., Psychologist

Micheal Reese Hospital, Chicago, Ill.

Chapter VIII

CONCEPTS OF THE UNCONSCIOUS

By HARRIET P. RAY, M.A., Psychologist
Michael Reese Hospital, Chicago, Ill.

I. Definition

What is meant by "unconscious?" This question presupposes another: what is meant by "conscious?" Freud calls "conscious," "the conception which is present to our consciousness and of which we are aware, and let this be the only meaning of the term 'conscious'."¹ And he continues, "As for latent conceptions, if we have any reason to suppose that they exist in the mind—as we had in the case of memory—let them be denoted by the term 'unconscious.' Thus an unconscious conception is one of which we are not aware, but the existence of which we are nevertheless ready to admit on account of other proofs or signs."

The unconscious contains "not only latent ideas in general, but especially ideas with a certain dynamic character, ideas keeping apart from consciousness in spite of their intensity and activity."

Latent ideas which may penetrate into consciousness, such as facts which we remember or recall, are *preconscious*. But some ideas do not penetrate into consciousness, no matter how strong they may be; these latter belong to the unconscious proper—indeed, they seem to be quite cut off from consciousness. Yet it is these processes, of which we have no conscious knowledge, which nevertheless determine our thought and act.

This, then, is the way in which the terms "conscious," "unconscious" and "preconscious" are used. Now the idea of the unconscious is very old. One cannot say when speculation concerning unconscious forces began; we can judge only by the few writings that have been preserved through the centuries. We know that Plato and Aristotle, the most important of the Greek philosophers, had some conceptions regarding this aspect of mental life, and that others, less well-known, also expressed their viewpoints on the matter. These, along with the pre-Freudian views, are of historical interest, but more than that they trace the development of man's thinking about himself up to the time of Freud's unique contribution.

II. Pre-Freudian Views of the Unconscious

Unconscious theory arose through contrast with consciousness. Descartes, holding consciousness to be self-evident, established a definite dualism of mind and matter and classified some ideas as "innate." He taught that the human body was a machine which was governed by a rational "soul." Lord Herbert and Cudworth supported Descartes' theory of innate ideas, but Malebranche rejected it.²

A. The German School

The German philosophers constructed positive theories of the unconscious. Leibniz held to the continuity of existence, differences in degree being simply differences in distinctness. Self-consciousness shades off into consciousness, and consciousness into unconsciousness; but in our development we pass from the lowest form of appetite (blind impulse) to the highest, in which desire and volition are the chief components. Before we have conscious striving or volition we must have unconscious striving, or blind impulse. Hence, for Leibniz, the unconscious is necessary to clear perception; and though he holds that there are uncon-

scious perceptions which influence subsequent conscious thought and action, his conception of the unconscious is not that employed by Freud but rather like the "subliminal" consciousness³ of the psychologists Fechner and James.

Kant² was not at all concerned with the unconscious and had very little to say about it in his philosophical writings. For him, the unconscious consists simply in non-conscious processes, in other words, in processes of which the individual is unaware. The complex generative processes of which self-consciousness is the product cannot be known by introspection, but are hypothetical and non-conscious. Kant termed those activities that generate consciousness and fall outside it "productive imagination," a non-conscious (unconscious) process.

Schopenhauer³ developed a more metaphysical conception of the unconscious than did Leibniz, but like him, maintained in it the principle of continuity. He regards the unconscious as the individual's Will to Live, an inner impulse or striving, a continual search for more adequate self-expression, which gives rise to his feelings and emotions. This Will is a "thing in itself," the essence of all life—indeed, a cosmic force, the fundamental principle of the universe.

Three aspects of his doctrine bear directly on Freud's conception of the unconscious:

1. Unconscious Will is irrational, a blind impulse in comparison to which reason is powerless.
2. Unconscious Will influences our conscious thought and action, while we believe that we volitionally choose our goals (compare with the Freudian mechanism of Rationalization).
3. Unconscious Will underlies racial existence, operating through individuals to further its own ends (this last conception—a racial one—has been revived by Jung).

On the whole, Schopenhauer's conceptions are quite speculative

and vague. Freud's conceptions, on the other hand, are based on observation and fact which are quite apart from the scope of Schopenhauer's.³

Herbart² stated that ideas are driven into the unconscious according to certain mechanical principles. Forgetting is due to a conflict between the ideas themselves, the point below which ideas become unconscious being the "threshold of consciousness." He conceived of the unconscious as both static and dynamic. In the static unconscious there can be co-existence of ideas without conflict; and in the dynamic unconscious active ideas operate as important factors in determining conscious states. In brief, his theory takes account of ideas and their relations.

Hartmann was influenced by Schopenhauer but elaborated the conception of the unconscious; for example, he tried to establish the relationship of unconscious processes to simple mental activity. As he saw it, the unconscious is a combination of unconscious will and unconscious idea. Like Wundt, he believed that perception was an unconscious process and that only its results were conscious. Also he believed that the unconscious really selected the ideas of conscious thought, whether as regards abstract thinking or imagining. He referred also to wit, which "clearly reveals its unconscious origin by its refusal to yield to conscious, intentional effort."³ And in his opinion the unconscious presides over the movements of the stomach in digestion (compare the recent findings from psychosomatic research). The student who wishes to read further the views of Hartmann, which have considerable bearing on psychoanalytic technique, is referred to his book, *The Philosophy of the Unconscious*, in which he expounds his theories regarding instincts, mysticism, character, the origin of language, morality and history.

For both Schopenhauer and Hartmann the conception of the unconscious was metaphysical and hence was held in contempt by many psychologists and other scholars. Nietzsche did not add

to their conceptions. He too recognized the influence of unconscious motives in determining men's actions, conscious motives being only rationalizations, and averred that these motives are the *real* ones. Realizing that true, underlying motives are unconscious, he recognized that the unknown qualities are subject to other laws of development than are the known qualities.

In respect to these unconscious forces Nietzsche³ regarded consciousness as immature, considering it to be much later in development than the unconscious. In *Joyful Wisdom* and *Will to Power* he discusses the general biological function of consciousness, which he terms "the latest development of the organic," hence the "most unfinished and least powerful," and speaks contemptuously of conscious activity as "superficial and credulous," that the conscious "judges perversely and dreams with open eyes." He held that man's preservation is due to the unconscious, or the instincts (compare Freud's Eros, or life, instinct), yet regarded consciousness as evidenced in ability to think to be the most original in man.

B. The British School

While the German philosophers attempted to build up positive theories of the unconscious the English criticized them. Thomas Reid and Dugald Stewart completely rejected the postulation of an unconscious, the former by saying simply that it is non-existent, the latter by maintaining that the doctrine of association is sufficient to account for all the facts.²

Some, however, re-stated and modified the earlier theories; for example, Sir William Hamilton attributed unconscious phenomena to mental latency—stating knowledge possessed exceeds that of which one at present is unaware, that systems of knowledge of which one is unconscious may reveal themselves in abnormal states, and that mental modifications of which we are unconscious are constantly influencing our conscious life.

John Stuart Mill and William Carpenter proposed physiological theories to account for unconscious phenomena, ascribing them to "nervous modifications."

MacNish and Abercrombie considered the manifestations in dreams, delirium and somnambulism as due to "contraction of consciousness."

However, there was one Englishman who made a specialized contribution to concepts of the unconscious. This was Samuel Butler,³ whose theory of unconscious memory was first presented in *Life and Habit* (1877). In essence, this theory, which is related to that of Hering, attempted to correlate the facts of growth and reproduction, instinct and habit, with memory proper.

Unconsciousness is synonymous with what was known well, as, for example, some learned, mastered, habitual act which no longer requires conscious effort as it did in the beginning. This view is historically related to Hering's, who first expressed it in a paper delivered in 1870, "On Memory as a Universal Function of Organized Matter." Hering stated that memory is a faculty not only of our conscious states but much more so of our unconscious ones. An individual is conscious of something at one moment, then at a later time is again conscious of the same thing. Where do these ideas go when we are not aware of them? (For Freud these ideas belong to the preconscious.)

Butler's hypothesis belongs to the study of psychophysical relations, which concern biological and physiological phenomena as well as the psychological. In the main it involves the following principles: (*Unconscious Memory*, 1910, p. 19).

1. The "oneness of personality between parents and offspring."
2. "Memory by the offspring of certain actions which it did when in the persons of its forefathers."
3. "The latency of that memory" until something revived it.

4. "The unconsciousness with which habitual actions come to be performed."

Butler regarded Hartmann's view of the unconscious as metaphysical. But he felt somewhat as did Leibniz, who anticipated his theory, that unconscious processes form the nucleus of personality and that "every molecule of matter is full of will and consciousness." (*Memoir of Butler*, H. F. Jones, Vol. I, p. 333.)

C. The French School

French philosophy was influenced by the English empirical school. Cabanis introduced physiological factors as the basis of conscious states, maintaining that the whole state of the organism determines the quality of consciousness. During the nineteenth century opposition to the materialism of Cabanis arose and there was a reaction in the direction of a spiritualistic psychology and the development of a theory of activity. But there was practically nothing concerning the unconscious.

With Ribot, however, a new era of French experimental psychology began. Though Ribot was noncommittal when it came to the unconscious, he did recognize that some theory of the unconscious was necessary to explain mental phenomena. He regarded subconscious activity to be physiologic rather than psychologic, and divided the subconscious into two levels: the static—which comprises habit, memory, and all organized knowledge; and the dynamic—a latent state of activity from which come spontaneous ideas, inspiration, creativeness (as in invention and improvisation), and even repartee. (His "static subconscious" may be compared to Freud's "preconscious," and his "dynamic subconscious" to Freud's "unconscious".) With Ribot began the movement which resulted in the important contributions of Charcot and Janet, who will be discussed later.

D. The Experimental Psychologists

The experimental psychologists dealt with conceptions of the

unconscious from another point of view and with a scientific approach. Fechner did not hypothesize very much on the unconscious but was concerned rather with the phenomena of perception and consciousness. In his presupposing of a "threshold of consciousness" was the implication that there was something below the threshold. He observed that the dream state was not similar, psychophysically, to the waking state—an observation to which Freud refers in *The Interpretation of Dreams* (pages 39, 40 and 424), finding that it confirmed his own conception of the difference between dream activity and that of the waking state. (It was in his study of dreams that Freud first elaborated his view of the unconscious.)³

Fechner's viewpoint* on the unconscious is like Leibniz's "little perceptions," the simplest constituents of consciousness, which Fechner calls a compound of atoms. For Fechner, consciousness is everywhere and in everything; also he believes that there is a principle of continuity (stressed by Leibniz and Schopenhauer) which is universal and pervasive.

William James attributed the automatic character of habitual acts (Butler's unconscious memory) to "conscious activity which is so rapid that no memory of it remains," or to a split-off cortical consciousness. He explained the phenomenon of *association* (as did Hartmann also) as due to a conscious activity performed in the past and now forgotten, or simply to activity of the brain tract. James' basis of the explanation of mental processes is organic—brain-modifications, "short cuts in the brain"—and he declared that the assumption of unconscious mental processes was unwarranted. For him, "all the phenomena of instinct are explicable as actions of the nervous system, mechanically dis-

* Fechner's conception of pleasure and pain agrees essentially with the psycho-analytic viewpoint (Freud refers to him in *Beyond the Pleasure Principle*). For Fechner, the inclination of the psychic apparatus to follow a pleasure principle is in accord with his principle of the Tendency towards Stability.

charged by stimuli to the senses." (*Principles of Psychology*, Vol. I.)

In the foregoing brief sketches of these pre-Freudian views on the unconscious we have seen that several individual thinkers have believed in the existence of unconscious phenomena and have been aware of its importance for behavior. Their concepts were based on varied deductions, but yet they were all somewhat vague and quite speculative and were not all amendable to scientific scrutiny. As a consequence, classical psychology rejected the conception of the unconscious as postulated by the philosophers and explained the facts of mental phenomena by psychophysical or organic hypotheses.

With the scientific approach to the study of neurotic manifestations and with the development of experimental and physiologic psychology a serious, academic interest in unconscious mental processes arose.

III. The Development of Psychopathology

A. The Intellectual Approach

(It was Charcot whose work laid the foundation for the scientific study of mental phenomena, for the present psychologic conception of the cause of neurosis began as a consequence of his investigations.) In the latter part of the nineteenth century, at the Salpêtrière in Paris, he carried out his well-known studies on hysteria and performed some outstanding experiments with hypnotized, hysteric patients. (This work led to his discovery that morbid ideas were capable of producing hysteria and that such ideas, as well as the symptoms produced by them, could change through hypnotism.)

Though he stressed the organic point of view in regard to the cause and nature of hysteric symptoms as due to some deficiency in the brain, nevertheless his conception of the pathological ideas

present in hysteria and his discovery that symptoms could be produced or eliminated through hypnotism indicate that his approach to the study of neurotic behavior was in essence psychologic. Thus his investigations mark the beginning of scientific psychotherapy.⁴

(Bernheim, of Nancy, developed the research into the nature of hypnotism and went much further than Charcot.) Discovering that the human mind, when in a proper state, accepts without proof and even against reason statements made by someone in authority, he came to interpret hypnotism as "suggestion" and the manifestations it produced as the result of suggestion. The cause of hysteria lay in one's native tendency to be suggestible; therefore this same tendency could be exploited in effecting a cure. According to Bernheim, suggestion differed from hypnotism only in degree and so could be used therapeutically in the waking state.⁴

While Charcot stressed the pathologic aspect of hypnotism, Bernheim had a theory which was psychologic. Janet, following these men, brought about the next advance in the psychologic approach, using hypnotism as a method of investigation. He formulated the concept of *dissociation of ideas* or personalities and believed that the unconscious was merely a part that had been split off from consciousness. His viewpoint was that mental life is a complete unit, synthesized by a certain psychic energy or tension. In the neuroses, or the dissociation of personalities, there is a split in the psychic energy, neurosis representing a breakdown of the synthetic function of consciousness. Janet entirely disregarded inner conflict in his conception of neurosis and gave no consideration to unconscious forces as the cause of neurotic symptoms; rather he believed that neurosis was of organic origin on a hereditary or acquired basis.⁴

Morton Prince, in this country, adopted the methods of the French school to some extent and contributed much to the under-

standing of the dissociation of personalities. Latent and forgotten memories comprise the "coconscious" ("actual subconscious ideas which do not enter the content of conscious awareness"), and coconscious images are elements of the subconscious processes which are perservations and sometimes elaborations of antecedent experiences. Prince attributes emotions and affects to the activity of the subconscious processes, which give rise to moods that cannot be explained on the basis of conscious thoughts.⁵

The "subconscious" was widely discussed forty years ago and is a term which is in popular usage today. By definition it was considered to be that portion of our field of consciousness which is outside the focus of our attention—the marginal states, or the fringe of consciousness—the prefix "sub" (under) denoting diminished or partial awareness. It includes dissociated ideas and past conscious experiences which either have been forgotten or may be recalled.

There were three types of theories regarding the subconscious:⁶

1. For the layman the subconscious was merely under the conscious, having a personality that acted upon and influencing our conscious life.
2. For the physicians the subconscious was not a physical foundation but was pathological or artificial in that it constituted split-off mental material which might fuse into a new, detached personality.
3. For the psychologists the subconscious was not psychological but belonged to a physiological process in the brain.

The foregoing conceptions of Janet, Prince, and others of this school, as well as the studies of other professional men which are about to be discussed, constitute an intellectual approach to the neuroses but with no regard for the dynamic motivation involved.

B. Further Growth of Physiologic Psychology

As clinical psychology with its changing viewpoint was developing, the school of experimental or physiologic psychology, pioneered earlier by Helmholtz and Fechner, was also growing. Through physical and physiologic experiments, reflex responses as well as normal individual reactions were interpreted in terms of the neural mechanisms involved. Hence, all abnormal manifestations (which would include the neuroses) were to some extent regarded as the result of qualitative or quantitative disturbances of neural functioning.

Research in physiological psychology was furthered by Pavlov, whose work on conditioned reflexes is widely known. (By definition, a conditioned reflex is a physiological response to a secondary stimulus which was not originally capable of eliciting that response.) Now from a purely physiologic point of view, irrespective of the psychologic, *all* behavior, whether normal or neurotic, might be interpreted in terms of conditioned reflexes (compare the studies of the experimental production of neuroses by O. D. Anderson, H. S. Liddell, Norman Maier, Jules Masserman, and others). Our most complex behavior may be the consequence of very complicated series of reflexes which are conditioned, reconditioned, or inhibited.

Among the experimentalists was Sir Henry Head, who demonstrated that the earlier, cruder forms of central sensory function are associated with the activity of the optic thalamus; his work gives a clue to other psychological properties of instinct.

W. H. Rivers,⁷ a colleague of Head, distinguished between instinct and intelligence, such as that instinct is innate whereas intelligence is acquired, and that instinct is the product of sub-cortical activity (this was also the view of Lloyd Morgan) while intelligence is dependent on cortical activity. Rivers regarded functional nervous disorders to be due to the weakening of the controlling forces. Later he applied the term instinct to innate

mental processes and categorized them as protopathic—connected with the needs of the individual (compare Freud's ego, or self-preservative, instincts), or epicritic—subserving the welfare of the group (compare Freud's sex, or race-preservative, instincts).

In citing Head's experiments, Rivers stated that the protopathic sensibility has the characteristics associated with instinct, while the epicritic belongs to intelligence and reason, and he believes that the protopathic remains dissociated or suppressed in adult life.

Rivers⁸ regards the unconscious from an evolutionary point of view and considers it the "home of the instinct." He says that experience becomes unconscious because instinct and intelligence are incompatible with each other. But dissociated experience persists because of the inherent strength of instinct and because suppressed experience forms an integral part of a complex, the other constituents becoming part of the personality of the individual.

For C. S. Myers⁷ instinct and intelligence are inseparable in the intact organism, instinct severed from intelligence being indistinguishable from reflex activity. He does not think that we have sufficient evidence for Rivers' belief that in intact organisms the protopathic and the epicritic systems have undergone "dissociation"; rather he believes that this protopathic (instinctual) element is fused, not dissociated. Repression may occur when instinct conflicts with intelligence (compare Freud's "ego"); thus what is forced down into the unconscious is not just the protopathic constituents but the entire experience involved in the incompatible conduct: This fusion of the protopathic and the epicritic aspects is the prerequisite for the experience of the unity "instinct-intelligence," so much so that when a conflict between these two factors occurs repression takes place.

Graham Wallas⁷ does not deny suppression or dissociation, but argues that it is not the most effective way by which people

control their instincts. He feels that mastery is accomplished through conscious understanding of our instinctual feelings.

James Drever⁷ does not accept that the term "unconscious" be restricted to abnormal phenomena of dissociation only, for he believes that the unconscious covers a wide group of psychological facts of which instinct is only a part, and that primary emotions are tied up with instinctive behavior. Just as the earlier, original protopathic sensibility is not found in the intact organism after the development of the epicritic, so also will not the pure, original instinct be found after intelligence has developed. He believes also that our primary mental system, or instinct, is dominated by the pleasure-pain principle and that our secondary mental system is dominated by the reality principle.

The unconscious is unconscious, he says, "because it represents either a stage of psychical evolution beyond which we have passed by normal development, or a mass of experience upon which we have, as it were, tried to turn our backs by some more or less abnormal process of dissociation, repression, or substitution, but instinct has precisely the same psychological position and function in subpersonal as in personal consciousness."⁷

A prominent psychologist, William McDougall,⁷ devoted years to the study of instinctual behavior. He states that the unconscious denotes facts of two distinct orders: those of mental structure and those of mental functioning, of which the individual is not aware; and so when we discuss the relation of instinct to the unconscious we are discussing the relation of instinct both to the innate mental structure and to the unconscious mental activity. He does not hold to Rivers' opinion that instincts are suppressed and dissociated, but believes that, "The instinct continues to determine behavior of appropriate kinds accompanied by the appropriate emotional experiences and therefore is not dissociated." And he continues, "When any experience issues in a strong affective reaction which is opposed to the general tendency of

the total system, there is conflict which may result in the dissociation of the cognitive dispositions concerned in that experience;" but, "The instinct itself, or its affective disposition, retains its connections with other cognitive systems, is not dissociated, and therefore continues to play its part in personal consciousness and activity."

McDougall's psychology, in recognizing that the driving power of the instincts determines behavior, is a dynamic psychology, or as he calls it a "hormic" psychology (Aristotle's "horme," or psychic energy).

Up to now, all the viewpoints discussed which pertain to the interpretation of mental processes have ranged from the somatic to the psychologic, with the latter usually on an organic basis. But it was for Freud to formulate a purely psychologic concept of the etiology, development and treatment of the neuroses.

IV. Freud, Jung and Adler

A. Freud and His "Dynamic Motivating Unconscious"

Freud began his medical career in Vienna, later becoming interested in neurology and neuroanatomy. His interest took him to Charcot's clinics in Paris, where he became acquainted with the views on hysteria which were held by Charcot and Bernheim. Upon his return to Vienna and his practice of neurology, he began to work with Breuer, who was using an analytic method of his own (catharsis) along with hypnotism. Freud shortly became dissatisfied with hypnotism as a therapeutic technique and eventually discarded it in favor of analytic procedure alone. He had discovered that early sex experiences or traumas were significant in the causation of hysteria, and since Breuer would not follow his views they soon parted and Freud continued on his way alone.

Except for Breuer, Freud was little influenced by Charcot and Bernheim and still less by Janet. Independently he came to the

conclusion that neurosis was caused by conflicts within the unconscious (previously, conflict had been considered to be in consciousness itself). Finding out that he could not uncover through questioning those events which had been forgotten and which for the most part were unpleasant, Freud reasoned that the "force" which prevented their rising to consciousness (resistance) must be the same as that which excluded them from consciousness. It was thus that he came to the idea of repression. "This, together with the discovery of the significance of early childhood and *infantile sexuality*, the notion of a dynamic, motivating *unconscious*, so different from all other notions hitherto entertained, and the idea of conflicts constituted the fundamentals of psychoanalysis."⁴ His concept of transference, quite as basic, followed later.

As Freud sees it, the law of causality, which operates in the physical world, holds for the psychic sphere also. Nothing occurs by chance; nothing is haphazard. And so he formulated the law of psychic determinism, which states that every mental process is the result of other mental processes which have preceded it. The structuring of the mental systems of the unconscious, the preconscious, and the conscious, together with their functions and interrelationships, and the dynamics of unconscious processes which he derived first from his study of dreams constitute the science of psychoanalysis and can well be regarded as one of the major scientific contributions of the century.^{9 10}

What is this unconscious like? What are its characteristics? First of all, its wish tendencies are charged with energy and are not mutually exclusive, contrary wishes existing simultaneously. Hence it knows nothing of negation nor doubt; it has no "logic." Secondly, its energy charges are freely mobile, as in displacement and condensation. Thirdly, unconscious processes are not related according to time (for time is non-existent), and nothing is forgotten. Fourthly, the unconscious is not subject to the reality

principle but is controlled by the pleasure principle. Fifthly, contrary ideas mean the same thing and are interchangeable (this same phenomenon is present in the early forms of language, primal words having an antithetic sense). And sixthly, in the unconscious there is an absence of verbal cloak or covering—the union of object and word being a characteristic of the pre-conscious, which overlays object-presentation with word-presentation.

B. Jung's "Personal and Collective Unconscious"

Jung,¹¹ considered to be Freud's most brilliant student, at first accepted his teachings but later broke away and in some respects went into a speculative psychology which borders on mysticism. He discarded the dynamic view of the unconscious and evolved instead a *personal* unconscious and a *collective* unconscious.

The former lies close to consciousness and contains latent memories of all the experiences through which the individual passed since birth. Those thoughts and feelings which would be unacceptable if one were aware of them constitute the "suppressed complexes."

The racial, or collective, unconscious contains inherited racial impressions which are the deposit of racial experience. It is composed of archetypes and instincts. As Freud¹² already pointed out, the archetypes consist of inherited patterns of thinking and feeling among all racial groups. They appear in myth and fairy tale, in the fantasies of children, in the dream life of adults, and in the verbal expressions of psychotics. The wishes and the fears of innumerable generations have led to these inherited engrams, and it is because of their primitive characteristics that these ancient patterns were called by Freud "archaic."

The instincts represent inherited action-pattern responses and serve either preservation of the individual or preservation of the species.

For Jung the libido is a universal force (the Schopenhauerian concept) and is not, as Freud sees it, the energy derived from the sexual instincts. Jung does not regard conflict to be between the ego and instinctive energy nor between ambivalent impulses in the unconscious, but between adapted and unadapted functions. He considers conflict to be purposive—necessary to adaptation to life; this view, as well as others which he holds, are teleological and hence are outside the scope of scientific psychology.

Jung, however, introduced the concepts of introversion and extraversion; and his concepts of animus and anima, the persona and the shadow are of great value in analytic understanding and interpretation and can be integrated also in Freudian psychoanalysis.

C. Adler's "Will to Power"

Adler⁴ used Freud's terminology but discarded his teaching. He rejected the idea of the unconscious, speaking only of "degrees of awareness," denied the fact of repression and rejected the existence of infantile sexuality. For him everything is purpose—teleologic—the purpose being the Will to Power (Nietzschean concept), a desire for superiority over others. This Will is, in the neurotic, a reaction against feelings of inferiority which are rooted in organ deficiency, and this striving for power (which he called the "masculine protest") is the guiding fiction in all neuroses. Frustrated in striving, the individual flees from reality and develops symptoms as an excuse for his failure. Adler built his whole psychology around this notion of organ inferiority, and centers in it every form of human activity.

V. Concluding Remarks

At the beginning of this chapter we defined the unconscious, the preconscious and the conscious by Freud's own definitions,

which are in acceptance by those whose work or study concerns psychopathology or personal interactions. The relationships of these mental systems to each other and the nature of their contents cannot be discussed in this brief chapter. Also it is beyond our scope to elaborate the formulations and the dynamics of ego, super-ego and id, the pain-pleasure and the reality principles, the complexes (such as the Oedipus complex), and the psychodynamics of fixation, regression, displacement, condensation, sublimation, reaction-formation, conversion, ambivalence. Rather should the reader consult the original sources themselves, that is the writings of Freud which clearly delineate these concepts and illustrate them by example.

In the preceding pages many viewpoints on the unconscious were presented as an attempt was made to trace the development in man's thinking about himself up to the present time. During the last century there were many divergencies of opinion concerning the unconscious, the subconscious (or subliminal consciousness), the coconscious (or alternating consciousness), and the conscious; and many hypotheses were advanced.

Psychoanalysis conforms to the criteria of scientific investigation in its methods of observation, the correlation of the facts observed, and the logical deductions of laws from these facts. The unconscious is no longer a hypothetic entity, for since its fundamental concepts have been established by a tremendous amount of evidence its validity cannot be doubted.

Thus far, psychoanalysis has provided better and deeper insights into all human behavior, both normal and abnormal, than all the preceding psychologies have given; and it was Stanley Hall's opinion that nothing since Aristotle's categories has gone more deeply into the exploration of psychic life than has psychoanalysis, and that it will have a far-reaching influence. This has come to pass, for it has created a whole new language which gives meaning to psychopathology and which is used under-

standingly by both therapist and patient, and it has widely influenced the range of human thought and endeavor. Psychoanalysis is no longer simply a therapeutic method but, as Thomas Mann said,¹³ "a world movement which (has) penetrated into every field of science and every domain of the intellect: literature, the history of art, religion and prehistory; mythology, folklore, pedagogy, and what not—thanks to the practical and constructive zeal of experts who erected a structure of more general investigation round the psychiatric and medical core."

And in referring to Freud he continues, "This physicianly psychologist will, I make no doubt at all, be honored as the pathfinder towards a humanism of the future, which we dimly divine and which will have experienced much that the earlier humanism knew not of. It will be a humanism standing in a different relation to the powers of the lower world, the unconscious, the Id: a relation bolder, freer, blither, productive of a riper art than any possible in our neurotic, fear-ridden, hate-ridden world."

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Chapter IX

DISORDERS IN PERCEPTION AND IMAGERY

By HEINZ M. GRAUMANN, Ph.D.

Clinical Psychologist, Topeka State Hospital, Topeka, Kans.

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HEINZ M. GRAUMANN, Ph.D.

*Clinical Psychologist, Topeka State Hospital,
Topeka, Kans.*

Chapter IX

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By HEINZ M. GRAUMANN, Ph.D.

Clinical Psychologist, Topeka State Hospital, Topeka, Kans.

I. Perception, a Problem of Phenomenology

The concept of perception maintains a paramount position in scientific reasoning. As fundamental, or at least as one of the basic conditions for knowledge, it becomes one of the central issues for all epistemological investigations. It is the problem of the reliability, the value of its content, as to whether it represents reality, so that it can be considered as a basis for true judgment of reality.

In order to answer these questions, one has to investigate the meaning of perception. To put this question as clear and unconditional as possible, we have to separate it from all related questions, as for instance, about the goal or the cause and even about the real existence of such a phenomenon as perception. Whereas many philosophers in the course of the centuries have limited themselves to a simple clarification of what they had in mind in speaking of perception and what they had implied in the concept of perception such as their more or less systematized opinions about the world, reality, thinking, etc., which they then deduced in their reasonings, the Phenomenological School, under leadership of E. Husserl¹ began the phenomenological analysis of the essence of just such "acts" as perception, as a part of a discipline which tries to investigate all acts and their objects correlated with their specific acts.

It is easy to see that the results of these investigations are important not only for philosophical and epistemological problems, but also for Psychology coping with the problems of perception. Psychology busies itself with the real events of perception in human beings (in general) or animals, in human beings belonging to a certain culturally or physically conditioned group, in different individuals, etc. It tries to find answers to such questions as: what real things and events, mental and physical functions (as causes, important conditions and special influences), make us have certain perceptions or make special individuals have deviating perceptions. Before we can know *how* one perceives, we have to know *what* perception is. Before we know what is different in the perception of a certain individual or group from the perceptions of others, or from most, or from "normal" people's perception, we have to know what is intrinsic in perception itself. That means that every psychological study is based upon phenomenological clarification and analysis.

II. What is Perception?

A. Four Aspects

It is the mental act in which the subject of this act acquires knowledge of an object by meeting this object during this experience. Whatever the object of this experience is, whether it is an object of the inner or outer life, whether a visual or auditive object, whether a certain, rather isolated quality, or a touchable and practicable thing belonging to a certain area and being in relation to other objects, all these different circumstances may give a different character to a perception, but are not intrinsic to it. Essentially we may say (a) that perceiving is not a producing act, but a passive one in which something happens to a subject, (b) that there is a subject which takes the object presenting itself into his mind and (c) that it takes the content of this experience as *this and this* object, i.e., having a certain meaning; finally,

(d) that the subject takes the presenting object as existing, and as such belonging to his real world and taking a place in this world which is more or less precisely determined (according to his knowledge). To make the significance of these statements a little clearer, comparison with similar phenomena is useful.

B. There Are Sensations Without Perception

Often *sensations* are defined as primitive entities out of which our more complicated experiences, such as perceptions, are developed. They are, therefore, according to a psychological theory, parts of perception. But the phenomenological observation shows that there are perceptions with sensations and others *without* them. Moreover, there are sensations without perception, namely, when something *prevents* us from perceiving, for instance, our hunger, our pain, a pressure, etc. *Sensations* are always closely related to the body image.² But they are on the object-side of perception like other objects, a chair, the movement of a wheel or a word. What distinguishes sensations from other objects of perception is their near relationship to the subject's body. When I see a running car, I see the auto moving but I don't know of any sensation of ocular movements although such movements may be necessary for perceiving the car in motion and although the sensation of these ocular movements may be perceived in a following introspection of the former perception. But such introspection is another perception distinguished from the first perception by having a different object from the first perception.

C. Perception Fused with Memory Objects

The immediate *presence* of the object in perception distinguishes the latter from an only *remembered image* where its object in one or another manner is connected with the past life and experiences of the subject. The objects in such memory images have the character of being only represented, being else-

where or as having met the subject in former times. But both, the perceived real objects and the imagined object in memory, can offer themselves as existing and in both cases the attitude of the subject is the same: the passive attitude of receiving something. This attitude of the subject may be the reason that the subject can be misled to take an only imagined object as really present, because the circumstances of his psychic situation prevent him from being orientated in this experience, by other experiences. This is, for instance, the case during falling asleep. The so-called *hypnagogic visions*^{3 4} show imagined objects and events from the memory of the subject (however transformed and combined from the original perceptions), with the subject, falling asleep, having no chance to detect the only representative character of the imagined objects in the clash with and the deviation from the world present in real perception, which usually accompanies the psychic life continuously. But the passive attitude of the subject is the same and this circumstance may tempt him to accept the "seen" objects as present. In falling asleep, the preventing circumstances making for orientation are common and are called normal, but other circumstances of the subject have the same disturbing effect without being common for all individuals, and are called abnormal. Taking remembered objects for real ones, or mixing both up in their perception leads to *illusions*. The patient who "sees" in the nurse his own sister or wife, the individual who finds the corner of his home street in a town never before seen by him, would not see these objects of his own memory if he had not seen something which becomes the perceived carrier of his experiences. His melting his real perception to his memory, points to conditions in the subject which make him mentally disordered or "abnormal."

D. Images of Fantasy

The objects of our *fantasy*, a person in a novel, a projected

musical theme, the *eidetic pictures* of E. R. Jaensch⁵ miss the quality of being really existing. The subject takes them as produced by himself, although he is not the creator of the fancied object, as for instance, in reading a novel or hearing the description of an object by somebody else. These qualities make the objects of our fantasy easily discernible from the objects of our perception, although in both mental acts the objects carry sensory qualities and are not merely conceptual formulations. It is understandable, that a subject mistaking the objects of his fantasy for existing things shows a more severe disorder of mind than in the mentioned cases of orientation prevented by stages of falling asleep, fainting, being partly distracted, etc. It is a deception about the subject's own attitude in the act and we assume strong emotional powers are at work in the subject in order to alienate him from his own acts. Such a high degree of disorder takes place, for instance, when an individual hallucinates the scolding voices and words of his enemies or the appearance of a person, of animals, ghosts, etc., in his empty room.

III. Gestalt Psychology

A. Against Element-Psychology

The endeavor of clarifying the meaning of perception leads to mentioning several disorders which just consist in the deceptive exchange or mixture of perception with these similar experiences. Before we proceed, however, in the investigation of these disorders and in placing them in a more or less strict classification, it is valuable to underline the theoretical result of our reasoning. The acts of perceiving, remembering, and imagining are different. When they are taken one for the other or mixed up, we have to do with cases of mental disorder, more or less usual or abnormal. It must be borne in mind that we don't understand any more what we are speaking about when we think ourselves obliged to deny distinctions, because psychological analysis pretends that in any

perception elements of sensation,⁶ memory,⁷ and free imagination can be detected. It may be that the one influences the other, but also other experiences much less akin than these, like feelings or emotions, have such an influence. It may be that so-called elements of one kind of these experiences can be detected in the others. But in any case they have been found there as functions which do not destroy the character of these different acts. Only in a psychology which artificially atomized our psychic life (in the manner of experiencing it) into psychological *elements* and autonomously functioning reactions, do we fall into the trap of feeling obliged to deny the distinction of acts which we, on the other hand, suppose again as different phenomena in order to justify the denial.

The Gestalt Psychology⁸ tries to evade this contradiction by refusing to analyze our experience into such psychic elements and only describes and inventories, therefore, such entities in our experience which present themselves as separately recognizable elements in and during our experiences. These are on the object side of our perception, the "Gestalten," which form together the organized picture of the perception, such as constancy, color, size, figure-ground relationship, etc., in visual perceptions; proximity, similarity, "closure," set, etc., in auditory perception. In this way, the Gestalt psychologists have succeeded in finding much more adequate descriptions of the contents of our perceptions. On the other hand, in their psychological theory, perceptions became the prototype of all mental structure, and only such theoretical transformation of the by far greater part of psychic life gave to Gestalt Psychology the semblance of being an adequate way of covering the whole of psychic life, of which the perceiving experiences are only a part. It is also not understandable why analysis in the description of psychic phenomena must stop by describing "Gestalten" and their experiences. From the point of view (which is that of the Gestalt Psychology) that psy-

chic functions and their correlates are to be described, it seems to me unjustified not also to state the relations with other psychic entities and with physiological functions obviously existent in our sensorial perception. It is finally the question for what end the description of psychic elements shall serve if not for explaining, although Gestalt Psychology seems to abstain from this.

B. Object Psychology and Comprehending Psychology

Thus, Gestalt Psychology is only a modified and limited form of Object-Psychology, standing in contrast to the Comprehending Psychology on phenomenological basis. The difference between both consists in that Object Psychology attributes to certain different psychic entities autonomous power and efficacy, thanks to which they are supposed to show their own nature, character, and function in the psychic totality. The Comprehending or I-Psychology denies the autonomous existence and power of such entities for the whole of psychic life and asserts that a directing, regulating and creating subject, the I, exists and this I, "a spiritual, real existing entity, bound by values, norms and rules leads the different psychic functions as expressions of the I itself."⁹ This psychology tries to understand psychic functions as acts of persons. This is most important for our problem of hallucinations. Not any more the variations of perception as a psychic function or of any other psychic function, but the changed attitude of the I towards itself and "the world" leads us to grasp this psychopathological symptom.

Making use of the findings of Comprehending Psychology, we don't want to neglect the investigations of other branches in psychology, especially as far as they busy themselves with the physiological aspect of our problem. Human perception is based on and bound by the functions of the body, its organs and nerves. The interference of these functions with psychological phenomena and vice versa is a truism. We must not omit, therefore, the findings

of Abnormal Psychology, in many respects dependent on the experiences, concepts and classifications of Psychiatry, and especially not in a chapter about disorders in perception, which is only possible if we consider perception as a psychologically functioning entity by itself.

It has been observed for a long time that the relations between psychological and physiological functions are often very hypothetical; moreover, that not all events in psychic life can be explained by physiological facts (as the only really existing things) and even that many physiological changes seem to be the effects of the mind. Beside the *physiological* explanations exist, therefore, the *psychogenic* explanations. This is seen in Psychiatry, for instance, as a basis for the distinction between the organic and functional psychoses. When we try to explain the slowness of all psychic functions (and among these of perception) of people in a depression or with a depressive mental disease *by* this depression which shuts them off from or hampers the reception of outside and inside stimuli, we are giving a psychogenic explanation. Often both kinds of causes participate, in one or the other order, on the same psychic phenomenon and we have to mention this when we try to sort out the deviations in perception. It is also possible that the same deviation of perception in one case has organic or physiological causes, in another, for instance, in that of a hysterical or a conversive neurotic, has a psychic cause, namely an experience which has a traumatic effect on the psychic life of the individual and causes for instance, temporary blindness.

IV. Abnormal Perception

A. Sensory Disorders

The sensitivity for stimuli can deviate from the normal scatter in different respects. It can be exaggerated as in *Hyperesthesia* when, for instance, a weak noise appears to the patient like a

vehement turmoil, the light of a small candle dazzles the patient like the strong shining sun. Such exaggeration of the sensitiveness may relate only to one sense or be more or less general. Also the reverse phenomenon, the *hypoesthesia* and the *anesthesia*, the lack of one or the other sensation, happens. All three occur seldom in psychoses, often in neuroses, with hysterics, and in hypnosis. A hysteric can use minimal sensory impressions for his perceptions which escape the senses of a normal.

The interpretation of such deviant impressions, those arising from a knock on the door as a gunshot, from a small candlelight as sunshine, etc., is also called *illusion*. Impressions with the same deviations can be secured by subjects without leading to these illusions, i.e., deceptive perceptions. It is, therefore, the disturbed mind of the subject which makes him use the deviant impressions in this manner. But the fact that mostly neurotics or depressives are the victims of such changes in impressions, points to psychic conditions as the underlying cause of this hyper- or hypo-sensitiveness.

Other deviations arising from changes in the functioning of the sense organs may have also psychogenic causes. *Interlacing of colorfields*, *blurred visions*, in which the patterns, details and the spatial relationship to other objects in the visual field, have become blurred,¹⁰ ring scotomata, i.e., spells of blindness in ring form, other patterns of blindness in the perceived environment occur in cases of hysteria and war neuroses.¹¹ Similar are *spots* and *webs* before the eyes, *defective night vision* and *diplopia*, i.e., double seeing, caused by dysfunction of the muscles of the eyes which regulate the placing of visual stimuli on corresponding parts of the two retinae.¹²

Many visual and other sensory disorders are caused by injuries or diseases of the sense organs and the nervous system. We must content ourselves here with a few examples: spasms of deviations of the retinal vessels lead to permanent or transient impair-

ments in vision.^{13 14} A degenerative change of the optic nerve causes bitemporal or binasal loss of vision.¹⁵ Injuries of the optic pathways and the cerebral cortex have various effects on vision. For instance, the parieto-occipital areas of the brain may cause *visual extinctions* of objects in the field of vision, probably because the constant nervous energy is not sufficient to meet the extra demand of the pathological cerebral cortices.¹⁶ The patients show disorders in visual construction, oculomotor coordination, visual orientation and an incapacity to unite the perceived parts to a whole.

Irradiation from cortical labyrinthine areas to parietal and other zones cause deceptive sensations which lead to illusions of body motion.

Rosett¹⁷ calls attention to the frequent coincidence of such sensorial disorders with hallucinations. "Disorientation in the present surroundings in any of the sensory spheres which result from a loss of one or more sensory receptive areas of the cerebral cortex is marked by episodes during which hallucinations occur, in which the lost sensation plays a prominent part and which are localized in the hiatus of that sensory field." He concludes the injury produces the hallucinations which should consist of the vivid recall of those sensations. But he admits that he cannot explain what the particular agency is which thus activates the function of an associative system under these conditions. The fact that hallucinations often make use of these sensorial defects is important, nevertheless.

Hyperalgesia, the hypertrophic sensation of pain is either caused by organic diseases of the nerves or by affectively motivated concentration on pain sensations. *Hypoalgesia*, the diminished sensitiveness for pain can have different causes. In the epileptic coma, there is no consciousness and, therefore, no pain sensation too. In the torpor, the threshold of the susceptibility of stimuli is so high that almost these cannot be felt. The attention

of manics during strong emotions can be so absorbed that they don't feel even grave injuries. Hysterics can exclude some parts of their bodies from the sensitiveness for pain. Nevertheless, they don't lose the unconscious orientation through which they know to avoid grave injuries and pain, while some catatonics show complete *analgesia*, independent from their attention. The analgesia of the paretics concerns only the skin whereas the pain in the deeper layers of the body are felt.¹⁸

Mental deficiency slows down, hampers or prevents the perception of more complicatedly composed entities. The stupid see many details but not the relations through which these become a unit carrying a meaning of its own. Lack of leading information, and of expectation towards reality in thinking, impoverishes the result of the perceiving procedure.¹⁹ Lack of information is also the reason that they often cannot recognize the objects reproduced in pictures, whereas the same objects in actuality can be perceived without difficulty.

Also alcoholics and catatonics are sometimes not able to perceive things in reproduction, but the reason is that they miss some detail of the reproduced object, for instance the size or the color, so that they attribute an incorrect meaning to the whole and see in the reproduced balloon an egg, or in a rose a cabbage, (*incomplete perception*).¹⁸

Organic psychotics and epileptics show besides retardation of perception a tendency to perseveration of perceptions. Newly exposed objects are not only called by the same name as objects of previous perceptions, but also are perceived as being alike.

B. Normal Deceptions

Deceptions in the field of perception are usual in the daily life of every normal. They are favored by bad conditions in the visibility and audibility (noise, bad illumination, weak sense organs) and by acts of anticipatory and expectancy adjustment

on the part of the subject. Suitable change of the conditions leads easily to the correction of these deceptions. It depends on the character, for example, a superficiality and the emotional or affective state of mind of the single individual, whether and how many such deceptions happen to him. Alcoholics and manics show often a haste, carelessness and lack of attention for details in their perceptions which augment the amount of their deceptions but concentration and enforced attention make corrections easily possible. The failures in the perceptions of alcoholics, moreover, reveal often that their objects in one or another manner must have come into their mind, as their answers are incorrect, although they point at objects with an obvious relationship to the real objects; for instance, a table is mentioned as a chair, an 8 as a 6, a flowerpot as a watering can.

But when we understand why manics have incorrect perceptions and many deceptions because of their lack of interest in the objects themselves, their lack of attention and the shallowness of their observation, we do not yet know why they have just *these* false perceptions, why they, for instance, read the 8 for a 6 and not a 7 or 9, or why the above-mentioned patients see their mother or sister or wife in their nurse. Psychoanalysis²⁰ tries to give the answers to this question about the *content* of such deceptions. Drives, wishes, fears are the reasons for it. We all, occasionally miss the adequate orientation to a situation and see the desired or feared object only because we *wish* or *fear* it. The really encountered object is just more or less similar or otherwise related with it. How much similarity is necessary for such deception, depends upon the power of the emotions or our capacity to control ourselves, upon our psychic situation. For the alcoholic and the manic, such a psychic situation seems to exist very often. Nevertheless, it is sometimes difficult to reveal the real motives for these deceptions, even after a long analysis.

C. Certain Details Missing

Often only certain details or qualities of the perceived object are changed in the perception. Some depressive patients see the whole world in a colorless gray, denying and eliminating color stimuli from the world which, according to their attitude and mood, has lost every value and attraction for them. Others don't feel any taste in whatever they eat and drink, because they don't permit themselves to enjoy this kind of pleasure. Others see all or certain persons in their environment correctly but lilliputian small, because they despise them. Or they see them walking on their heads, because they think them crazy, or with skulls or as skeletons because they hate them deadly. Such explanations appear very trivial in their simplicity (and often they are indeed more complicated), but we must not forget that the drives developing such power are very primitive and show themselves on these occasions in their real primitivity.

D. Artificial Illusions

There are other illusions, arising from the configuration of the stimuli which seem to resist the correction, even by concentrated observation. Aristotle described the illusion of the crossed fingers with which one thing is perceived as being two things, because we are accustomed by touching with the outer side of two fingers in the normal position two distinct and numerically not-identical objects. Since Necker (1832) numerous situations are found or constructed in which normals fall for the constellation of stimuli, and their perceptions are illusions.²¹

Such artificially caused illusions are used to analyze and clarify the components of our perception. It is asserted²² that there are three main forms of combination of perceptual units which together, or singly, can appear as perception: (a) Two or more sensory impressions can integrate in a single unit for experience. In this manner we experience wet as a unit of pressure on the

skin and cold. (b) The experienced sensory stimulus (as the core of the perception) is accompanied and molded by an image (as context) to a completely unitary, meaning-loaded experience. (c) In frequently occurring perceptions, the context drops out and the meaning is carried by a functional set of the nervous system called a determining tendency. Such "implicit perceptions" are involved in these last mentioned illusions, for instance, about visual size or directions of lines.

Whether the explanation of these illusions can be accepted or not^{23 24} need not concern us here. For Abnormal Psychology, these kinds of deceptive perceptions are without importance. They are in no manner indicative of any kind of mental disorder. With a change in the situation, any subject regains his orientation which immediately dissolves the deception. They are especially not to be taken for those phenomena with which we have to cope finally, with hallucinations.

V. Hallucinations

The separate discussion of hallucinations is given here for several reasons. The hallucination is one of the outstanding symptoms of mental or psychic illness. Sixty to eighty percent of the schizophrenic cases have hallucinations, about 35% of the manic-depressive group and 20% of the "organic psychoses." Hallucinations are, furthermore, the most characteristic sign for the detachment of a mind from reality, the diagnostic yardstick for the distinctions between neuroses and psychoses. This is true, although we have shown that many deviations in perception are also indicative and characteristic for psychoses. Still more important is that we never could arrive at the real meaning and significance of hallucinations if we considered them as another group of deviations of perception. That imagined objects for a subject are related to an outside world common and accessible to other people, as authentically present objects,²⁵ is a deviation

in imagination, not in perception. More precisely, it is a disorder of the whole personality in which the relationship between the different manners of experiencing, are abnormally changed. As long as we are looking for physiological or psychological functions due to which stimuli, perhaps only minimal stimuli, are misused in the falsely interpreting perception, we cannot see the essential role which the subject, the I, plays in such experiences. Only in the comprehensive approach will we see the catastrophe of the I whereby occur hallucinations, in comparison to which simple deceptions in perception appear rather innocuous. We can thus understand why the contents of the hallucinations always fit into the psychic totality of the patient, in his mental disorder and into his personal character as well, whereas the contents of perceptions can be independent of the personality of their subjects, at least to a high degree. We see also that hallucinations—except perhaps in cases of almost vegetatively living schizophrenics—never can be neutral as perception may be; on the contrary they have a special importance for the hallucinating person; they warn, admonish, offend, horrify, or satisfy him.

A. Great Variety in Quality and Content

A descriptive survey of the hallucinations and their clinical occurrence shows an almost unlimited richness of their varieties in quality and content. Hallucinations are different in the clearness and completeness of the hallucinated objects, in the intensity of their qualities, in the manner in which, whether and where the objects are located in the world, in the character of reality of the hallucinated objects, their relation to other objects of the outside world and to the hallucinating person himself. Combinations of all these variations occur, but each can be independent of the others.¹⁸ A patient has, for instance, to make the greatest effort in order to understand the words whispered by voices which yet at the same time seem to bite and cut like snakes and knives. And

the voices may be those of nobody, or of certain persons, and come from nowhere or out of the wall or from the shoulder of the patient. They may be completely different from all other things in the world or having the same, more or less, concrete reality and existence, be connected with or isolated from the rest of the world, etc.

B. Intensity and Frequency of Hallucinations

Psychiatric experience teaches that in acute attacks, especially in Schizophrenia, the *intensity* of the hallucinations can rise and fall together with the degree of the attack. Still more important are other qualities of the hallucinations which permit us to judge the severeness and/or the sort of the mental disorder itself. Hallucinations which in their contents are connected with certain more or less elaborated or systematical *delusions* point to a mixed form of schizophrenic and paranoic traits, because the clearest distinguishing feature of the pure paranoia is just the absence of hallucinations by their contents decrease the structure and destroy rectly perceived, the subject and his reality do not become disordered. Merely peculiar inferences are drawn from the events, forming a link in the delusional system. The more, however, hallucinations by their contents decrease the structure and destroy the space of the normal world of the patient, the more severe is the psychotic disorder, whereas frequency and accumulation of these hallucinations indicate not the degree of the disorder but the acuteness of a disturbance, as the subject is forced to busy himself with the contents of these hallucinations, which can dominate and overwhelm him completely. This is the case in relation to all functional psychoses, but not to organic, drug and alcoholic disorders.

In general there is no doubt on the part of the subject about the reality of the content of the hallucinations, although these are often considered as something special because of the strangeness of the hallucinations, since they were never experienced before,

such as a light in the heart, hearing with the hands instead of the ears, the appearance of a winged lion, a ghost, the Devil, etc. But as long as this strangeness is felt to be connected with the meaning of a higher degree of reality than the rest of the accustomed world, the severeness and completeness of the disorder is less than when no difference at all exists for the subject.

C. Pseudo Hallucinations

There are other hallucinations which are not placed in a common, outside world and miss the authenticity of the perception, although they appear unwilled by the subject. They can be very constant, distinct, elaborated in details, and intensive. The subject has more or less a knowledge that these "images," "voices," etc., exist only for him, or even only in his own mind. He characterizes this fact by describing it "as if" he were seeing or hearing somebody, something, or certain words, which are interpreted then—according to the content—as magically performed for him or as inspirations, prophecies, warnings. The character of reality is ambiguous for the subject. Especially delirious alcoholics show these *pseudo hallucinations* (Kandinski).²⁷ Following Bleuler often genuine hallucinations change into pseudo hallucinations when the intensity of a mental disorder is diminishing.¹⁸

D. Abstract Hallucinations

The similarity of hallucinations with perceptions can be even less. This is the case when the hallucinated object has no sensory quality, and is only experienced as, for instance, a cat without any size, color and position or a beast or only a "power," the meeting of which is experienced in the hallucination. These are more or less *abstract hallucinations*, occurring (but not exclusively) in schizophrenic disorders. Comprehending Psychology, considering these hallucinations as expressions of a disordered mind, considers in its concept of these hallucinations not only the detachment from the real world, but also from generally qualified objects.

E. Hallucinations Mostly Auditory

Usually hallucinations are ascribed to one or more sensory fields of experience. By far the greatest number are *auditory hallucinations*,²⁸ especially produced by schizophrenics, and almost always accompanied by vehement affects and emotions, and in verbal form. The schizophrenic literally answers these voices, or only with his thoughts which they may understand as well. The voices can also electrify or poison the patient; but in such experiences they already lose their proper sensual character and resemble the abstract hallucinations. Non-verbal auditory hallucinations, music, singing, are rare, occurring in deliria, especially delirium tremens and in ecstatic stages.

F. Visual Hallucinations

But when a person, as speaker of the words, is hallucinated, there is also present a *visual hallucination*. The production of visual hallucinations is favored when the controlling sensory orientation is hampered, as during the night, in motionless solitude, and in stages where the clearness of mind is diminished as in deliria. Sometimes the emotional factor, which had led only indirectly to this stage, has been burned out. Alcoholics can look at hallucinations for hours and hours like people in the movies at the pictures on the screen.

Where an object in the environment fails to be seen, we speak of a *negative hallucination*. It is doubtless a genuine hallucination and just as highly important as an expression of a disordered personality. Incidentally, those visual hallucinations in which hallucinated objects cover up a part of the environment, contain also these negative hallucinations and their hiding effect is often the proper clue for the comprehension of the whole hallucination.

G. Olfactory and Other Hallucinations

Olfactory hallucinations (hallucinations of odors) and *gustatory hallucinations* (of taste sensations) appear in the ecstasies

of paretics, or reveal disgusting or poisonous substances to paranoid schizophrenics.²⁹ They appear, however, mostly in company with other hallucinations, sometimes as so-called *extracampine hallucinations* localized outside the sensory field in question. The same is the case with the *haptic hallucinations*. Touches on the skin, pressures, bites, burns are felt. In *kinesthetic (psychomotor) hallucinations* patients hallucinate themselves walking, speaking, etc. They feel that people or other forces do something on, in, or with their bodies. All these kinds of hallucinations are often connected with elaborate delusions. Often heaviest pains are suffered.

VI. Phenomenological Psychology

As to the content of hallucinations, Campbell³⁰ mentions the *simple* and *impersonal* hallucinations, associated with a variety of toxic and organic conditions and the more *complex* and *personal* hallucinations, closely related to important preoccupations and often dissociated from the rest of the personality. The first group resembles more the perceptive illusions, the latter the imaginations of a disordered subject.

For both groups psychoanalysis has tried to give psychogenic explanations. The simple hallucinations are considered as conditioned sensory responses, conditioned by the perception of the initial stage of a previously punished act. The complex hallucinations are explained as wish fulfillment²⁰ or as projections of the super-ego.³¹ But although this may explain why an individual has a hallucination with a certain content, as for instance, in suffering certain sexual offenses or pains, etc., the enigma remains unsolved, however, as to how it comes that these experiences, arising from the mind of the subject, get the character of perceptions.

To answer this question the Phenomenological Psychologist*

* I am following here the ideas of L. Binswanger (33), v.d. Horst, Hugenholtz (9), v. Lennep (34).

analyzes our being-in-the-world,³² specially our concept of/and our relationship to reality. The "reality for us" is, of course, not the objective reality, the "thing in itself," but only that part of it which stands in relation to us, on which we participate, which has met us and has become a fact for us. Unknown areas on the earth, or unknown historical events or developments, all this only becomes real for us when it touches us in the "now" of our existence.³⁵

A. Criterion of Reality

Each human being has, therefore, his own reality, that part of the transcendent objectivity with its relations and rules which he accepts in experiences and cognitions. What we accept in such reality is the superior power in relation to ourselves, this being in itself, following its own universal rules, determining also our own life and before which we have to bow in our drives and wishes and their expressions in our imaginations. Always it is the appearance of the reality which corrects our images; always our imagery tries to tint and disform reality. The correction by reality makes us wiser. Each recognition of reality means at the same time clarifying the own inner life, a better knowledge of ourselves.

In other words the criterion of all reality is its relatedness. We experience in the appearance of reality its relatedness to ourselves and to the whole reality as well, of which it is a part in spatially and temporally ruled relations, and of which we are a part ourselves. Not only as physical beings, for there are also rules and relations which we accept with reality, for instance, historical conditions of our mental development. The acceptance of the relatedness of this reality teaches us to renounce that which is impossible.

But in imagination, everything is possible. It is free from this ruled relatedness. Everybody has his imagination, not only the phantasiast, the idealist, the artist. It depends on the degree in

which one can put aside one's imaginations and accept reality whether one is a mature and adjusted individual in the struggle of life and in the fulfilling of his physical, social, cognitive, etc., needs.

The normal person shows this achievement, difficult and painful as it sometimes may be for him. His I which directs and influences an integration of all his psychic components, curbs feelings and strivings, rates judgment one against the other, and regulates evaluations. The I confronts itself in accepting reality with the world and behaves in it aggressively or concedingly, asking, listening, etc. Most important, the I is the free and responsible actor of the human acts of will.

B. Loss of the Regulating Self in Psychoses

More or less all these functions of the I are lost in the psychoses, and accordingly some loss of responsibility can always be seen. The consequence on the course and structure of psychic life is different in the different psychoses. But always certain psychic functions gain an anarchic autonomy, absent in the normal personality. Their contents obtain an overrated significance and unlimited influence. The single acts or experiences don't fit in anymore with the pre-psychotic personality. The I is not able anymore to relate the reality to himself and to adapt the inner life, expressed in the imaginations, to the appearance of this ruled and regulated reality. The imagination secured a superior power which reality has for the normal psychic life. The experiences alienated from the I, the loss of his own continuity, his overrated feelings and judgments, the uncurbed forces of the drives, makes it impossible to the I to direct anything in his psychic life. Being unrelated to an ordered appearance of reality, the subject can neither doubt nor be convinced by facts, relations and laws. The psychotic has convictions which are not to be shaken but may be reversed the next moment. He lives in a completely

different world which has no fixed relatedness and arose only out of his own twisted and alienated imagery.

C. Witnesses of the Changed Structures of Mind

Hallucinations are the witnesses of this changed being-in-the-world. *They are imaginations posing as appearances of reality with the certainty of a sensory experience.* They are the signs of the dissolution of the human soul. The (pre-logic) certainty in the experiences and existence of the subject is lost.

All entities which hamper or prevent the functions of the I favor the appearance of hallucinations. These are such things as fear, fury, and affective sets like suspicion, hope, etc. But still the changed structure of mind itself is sufficient to make an individual have hallucinations. Therefore, the forms of the hallucinations can indicate the psychic disorder, the deteriorated structure of being-in-the-world, as we have shown by a few examples.

The phenomenological approach in Abnormal Psychology has not yet proceeded to ascertain how far the mentioned classes of hallucinations are systematically justified and permit strict diagnostic conclusions. Surely, many of the clinical observations are valuable and useful in the changed frame of investigation.

VII. The Patient's World an Object of Psychiatry and Abnormal Psychology

Psychiatry and Abnormal Psychology have been often reproached as a decisive judge of the attitude of an individual in his relation to reality and the social environment, as this province should lie *outside* of their proper medical science. The discussion of the hallucinations as a paramount sign for psychoses (and significantly for the functional psychoses) show, however, that the psychiatrist and clinician are completely right to include it in their study as one of the most important factors for a judgment of a disordered psychic life.

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**PSYCHOLOGICAL
TESTING
IN A
MENTAL HOSPITAL**

By

JOHN ARSENIAN, Ph.D., Psychologist
Boston State Hospital, Dorchester Center, Mass.

Chapter X

PSYCHOLOGICAL TESTING IN A MENTAL HOSPITAL

By JOHN ARSENIAN, Ph.D., Psychologist
Boston State Hospital, Dorchester Center, Mass.

There are many psychological tests, many mental hospitals and some uses for tests in hospitals. To a considerable extent, the setting in which tests are given determines why, what and how tests are employed. Asked to write about psychological testing in a mental hospital precipitates a somewhat different set of ideas than if one were to write about testing in industry or in schools. Also, it is probably true that another psychologist working in a mental hospital would write somewhat differently, either because his institutional functions or habits are different or because his theories or his personality differ. While an attempt will be made to maintain this discussion at a generalized level, it would indeed be surprising if parts of it did not reflect personal biases as well as procedural notes.

I. Diagnostic Testing

A. Diagnosis, An Act of Classification

When clinical psychologists are asked what is their special forte or function, and on examinations for positions in government and state service the business of diagnostic testing ranks high in order of mention. There are classes and classifications of all data that have been surveyed with a mind to ordering it. Classes and classification can answer the question "What are we confronted with?" and are convenient because they sensibly order

the stuff of experience indicating what some thing is in relation to other things, or what one may expect of or from it. A diagnosis seems to be an act of classification. The word itself has a magic, almost magnetic influence on non-medical persons—it has an aura of gravity, authority and sometimes finality about it—perhaps because of the connection between some disease and death. While the body yet lives, importance attaches to the actions of experts who can do things for it, also to the words of experts who can do nothing. Is it the aura that so attracts some psychologists to diagnosis?

The classificatory task in the diagnosis of mental illness involves sorting and choosing within an evolved, elaborate schema not altogether acceptable to many members of the psychiatric profession. There are official lists of mental diseases, but depending on variables like acumen, scrupulosity, respect for individuality and so on, persons employing these lists experience difficulties in fitting a given case to the master schema, designed or evolved to subsume all cases. The present classification seems partly naturalistic and descriptive—a product of an era in science marked by careful observation and comparison of data; partly pragmatic and prognostic—a consequence of interest in knowing what to do and what to expect; partly historical—a tribute to the person who first discerned a constellation of symptoms; and partly etiological—reflecting interest in the problem of origins and causes of a diseased state. The sources of some difficulties experienced with classification are inherent in these multiple criteria for classification, while other difficulties stem from the sheer variability of character constellations, the transitory nature of some mental states, and the silent nature of some mind stuff. Plainly there are different levels of observation and description and the same person may equally fit three or more classes—depending, say, on whether one chooses to classify on the basis of overt signs or covert thought processes, or forces inducing illness, and so on.

B. An Ambiguous Position

Psychologists may find themselves in an ambiguous position in this problem of diagnosis. First, diagnosis is traditionally regarded as the function of a psychiatrist. Secondly, psychological tests may and sometimes do produce constellations of "signs" which suggest a classification at variance with the judgment of the psychiatrist, who often has observed patients over a period of weeks or months and is naturally hostile when on the basis of an hour's confrontation with the patient being "quizzed," looking at pictures, and doing puzzles, a psychologist suggests the patient better fits a different category. Nor is every psychiatrist impressed when a psychological test confirms his classificatory judgment—he knew it anyhow. The business of straightening out the formal nosological tangle should be left to medical scholars who are surely competent to handle it.

Meantime it seems possible that psychologists can resolve this problem by avoiding it. One can readily see that several sets of criteria are possible cues for a classificatory act. Which criterion one selects is a matter of taste until the question of meaning and purpose is posed. If one considers classification not as an end in itself, but as means, or a cue to means of treatment, matters of taste in labelling give way to the pragmatic problems involved in saying useful, usable things about patients.

C. The Pragmatic Test

Three broad questions for understanding present themselves as pragmatically useful. First, how did the person get to be the way he is?—a historical problem. Second, what is the person like at the present time?—a descriptive, structural problem which includes inferences about "why" and is therefore also "dynamic." And thirdly what are the person's possibilities for change—a prognostic problem with a pragmatic emphasis because one is challenged to say how change may be induced—if at all?

It can be asserted and demonstrated that psychological tests may be useful in providing *some* data in these three areas. If one adds to an assessment of how the person is, material on how he got that way, and how he may change at some more or less near future time the sum approximates the total personality. There is ample precedent for psychological studies of the total personality. The broad and discriminating eclecticism of Dr. Allport's 1937 work on personality has many valuable leads for an expanded study of the person. Psychologists in mental hospitals have an opportunity to develop skills at the integration of fragments about personality so that phenomenologically apt descriptions of the total personality emerge. If psychologists can summarize succinctly the structure and functioning of a total personality, there will be no questioning their value in mental hospitals nor will psychiatrists feel that their diagnostic province and treatment prerogatives are poached upon.

If, on the other hand, psychiatrists ask for diagnostic aid—or one's institutional role calls for independent appraisal with a view to diagnosis—it can be provided. Clinical psychology is greatly indebted to Dr. Rapaport and his associates for their basic work in this area. On the basis of familiarity with constellations of scores from tested persons with the same psychiatric diagnosis, it is often possible to discern whether a new case approximates one or another type—and to what extent, and so state that psychologically the person is like a schizophrenic, or depressive or whatnot. Let us consider the tools with which the psychologist is emboldened to make such categorical judgments, but first a discussion of the problem of sampling in personality study.

II. Sampling of Personality

A. Limited Time Sample of Personality

It is usually a fact that psychologists in mental hospitals work

with a limited sample of a patient's behavior. Unless he is locally licensed to engage in therapy, he sees patients for the limited time required to administer one or several tests—a variable period depending on the productivity of the patient, the patience of the examiner, the time limits imposed by institutional work requirements, as well as the number of tests. One fact remains: psychologists tend not to see patients over extended periods; they see instead a small sample of the patient's total behavior—limited in its representativeness by the tests imposed and further by the attitude of the patient toward the tests and toward the examiner. It is rather wonderful that so much can emerge from these short samples which can be otherwise validated, but one should be cognizant of the reaches of inference involved in extracting a personality description from such data and become less “cocky,” more cautious in considering one's materials and role. It is exciting to be bold and right, but wiser to remember one is saying something about another person, and that the materials one works from are neither a crystal ball nor like a true measuring scale nor even like the scale of justice in some instances.

B. Question of Consistency

Also there are limitations on aspects of personality sampled via choice of tests and the limitations of scope within these. Before commenting on what is sampled there is an elaboration of the sampling problem which warrants mention. Even supposing one's brief time sample of the total personality is adequate, there is still an inference of *consistency* inherent in extrapolations from verbal behavior to describe total personality functioning. Mostly our tests revolve around words and visual material both in presentation and response. Obviously there may be a difference between verbal behavior and overt behavior. But the presumption of consistency is often unhesitatingly used in in-

interpreting psychologic tests. Suppose, for example, a person says, in response to an item in the Wechsler Intelligence Scale, that on discovering a fire in a theatre he would yell and run to the nearest exit, it *may* be that the person is "impulsive"—it is possible, but one has a very limited sample of even verbal behavior on the basis of which to make this inference, and, besides, this is a verbal response. The question remains would the person behave impulsively in reality? Tacitly assuming consistency—that verbal response equals behavioral response—begs the question. The inference of consistency may hit the mark in some cases, but is wild in others—most obviously in those persons who have excellent control of verbal behavior and a fine verbal awareness of their group's mores, but in acting out, demonstrate an extraordinary lack of control. Perhaps this variable of "consistency" is one which should be gauged rather than left an assumed constant or an unassessed variable error.

C. Significant Variables

Apropos of what is sampled, it may well be that the variables we now indicate are a sparse, poorly selected sample of the aspects of personality relevant and important in clinical practice. We indicate some aspects of personality refracted in our tests, but what are these? A miscellaneous collection of more or less ingenious tests stemming from school, college and army experience. A few minutes' reflection will produce a list of aspects of personality of far more interest to clinical practitioners than those most psychologists currently mention. For example, it would be useful if one could gauge a person's modal type of reaction to anxiety and frustration, the strength of his dependency needs, capacity for social compromise, thresholds for various types of response to deprivation or frustration, or anxiety, or guilt; his degree of complacency, his sensitivity and mode of response to criticism, his insight into own motives and awareness

of self-typical habits, his degree of rigidity or flexibility in likes and dislikes, and so on. Then, regarding more intellectual functions, persons interested in total personality structure and functioning for clinical purposes want to know more than a mental age or brightness index. One would like to know whether the person is functioning in reality at the level he scores; whether the person acts first, thinks later; how free the person is to use mental energy creatively; how much mental energy is available for new learning; what happens to a particular person's brightness under conditions of stress; whether newly learned material makes a difference on habit patterns; and so on. If psychologists could develop instruments to gauge some of these variables—among others—they would be in a much better position to contribute useful knowledge about persons than is generally possible from such good tests as the Wechsler-Bellevue, Rorschach, and Thematic Apperception tests. True, some clinical psychologists are intuitively gifted enough so that they can hazard statements about these aspects of personality from the aforementioned tests. But, are not some of these traits more directly testable? Then there is a set of ill-defined variables which have a bearing on the process of therapy. To gauge these, however crudely, will yield useful information for psychiatrists undertaking therapy. Such questions as how much there is of narcissism, how rigid are the ego defenses, how much readiness is there to positive or/and negative "transference," how strong is the super-ego, how much readiness is there to project, how much capacity for identification, how much of a compulsive need to be good, better, best; how much capacity is present for self-insight and change; how much tendency to act out reactivated fantasies; how close are the aggressive and sexual impulses, aggressive and striving impulses; how much is there of an uncompromisingness of super-ego and unconscious need for punishment. In short, it should be possible to devise instruments enabling us to say something about

persons which would have far greater potential usefulness for clinical practice than the materials in current use. Let us consider the materials now available and the interpersonal setting in which they are used.

III. Administration and Interpretation of Tests

Psychological tests not administered in a group setting are given individually—and therefore the setting is comparable in some respects to an interview. At once a source of strength and weakness of psychologists in testing mental states is the management of this interpersonal situation as if it did not exist. The psychologist strives to conduct a “standardized” interview such that variables like attention and motivation are constants, so that he can fairly compare his subject with other people—more particularly, the population from whom the test “norms” were obtained. Among so-called normal people who do pay attention and are motivated to do their best these presumed constants are not great sources of error in testing. But for hurt, angry, pre-occupied, anxious and mentally sick persons these assumptions should not pass unquestioned. Still, it is the possibility of handling a person’s responses to a standard set of questions and puzzles, rating them according to certain rubrics and manipulating them so that the individual’s results are placed in relation to a representative sample of the population—it is this standardization of procedure and the availability of “norms” that make psychometrist’s estimates of brightness more accurate than current practice in psychiatry. Lack of norms for reasonable tests of insight, judgment, intelligence and other variables make psychiatrists’ reports of “mental status” less accurately meaningful than corresponding psychological tests.

This advantage of a comparison population in making estimates of brightness, impairment or any other psychological variable seems not sufficiently appreciated by many psychologists who

in their eagerness to bring out new tests are deficient in their readiness to do the basic work involved in providing norms which make results meaningful.

A. The Three Basic Clinical Tests

The best basic tools for adult clinical psychological testing are the Wechsler, Rorschach and Thematic Apperception Tests.

Because it is assumed that anyone wishing to know about the Wechsler-Bellevue Intelligence Scale will read the author's manual, and similarly with the Rorschach and Thematic Apperception Tests, it seems more useful here to comment on some problems, procedures, and ideas which may assist the student in developing more than the clerk's abilities obtainable by careful reading of basic texts.

1. The Wechsler Scale

Regarding the Wechsler scale, for example, if one will make inquiry as to what psychologic functions are assessed by component subtests, one can easily see possibilities of reporting out more than an intelligence quotient. Bear in mind that there is nothing unwanted about a statement of brightness, but if a psychologist spends two hours with a person only to return a judgment that he is, say, averagely bright, members of other professions, including psychiatrists, will rightly cite him for dullness since they may reach the same judgment after ten minutes with the person.

Asking what sort of mental function is required to manage this and that subtest, places one in a position to add useful knowledge about a person. From those questions of "Information" one can extract some notion of the person's *awareness* and/or *retention* of a body of social knowledge. From the "Comprehension" items, *awareness* of a set of *social norms* and the rationale of certain institutional practices is tapped. The level of *abstract*

and *concrete* symbolic functioning is tapped by "similarities" and "vocabulary" tests. The capacity for insight and *trial and error learning* may be evaluated from the management of "Blocks" and the puzzles: "Object Assembly" and "Picture Arrangement." Intactness of *perception* is tapped in "Picture Completion" test, and *social perception* in "Picture Arrangement" and the so-called "Comprehension" subtest. *Efficiency* and *control of mental energy* are involved in performances with the "Blocks," with the "Arithmetic" problems and the substitution test, "Digit Symbol." The latter test and the more difficult block patterns also tap the variable of mental *rigidity*, and so on.

Thinking about the Wechsler Scale in this fashion enables one to make inferences about a number of important psychological variables like perception, cognition, the availability and control of mental energy and the role of anxiety in impairing performance, and so on. Despite the sampling problem discussed above, or, better bearing in mind the cautions suggested by it for the psychologist who has trained himself to be a keen observer, there is justification in commenting, tentatively where necessary, on these psychological processes underlying the performances of a particular person. So many psychological reports written into case records are stating that one score is higher than another score when the problem of communication requires that meaning be clarified in terms of describable psychological functions.

It is true that the recommended analysis of subtests for their psychological meaning requires "purification" of some subtests by eliminating items irrelevant to the psychological function putatively tapped by a particular subtest as well as adding items to bolster confidence in inferences because of the scant sampling. But this should be done anyhow. Also, it seems a simple step to alter the "Vocabulary" list without changing its difficulty so that it includes more than cues on "aggressive" feelings via words like "Nitroglycerine," "Guillotine," and "Hara-

Kari." The inclusion of other words of the "complex-indicator" variety would add to the diagnostic usefulness of this subtest. And along the same lines, a better selection of materials for the so-called "Picture Arrangement" subtest might make this very valuable for clues regarding areas of disturbance in personality. The clinical value of the Wechsler test would be thereby enhanced, without altering its efficiency as an intelligence test.

Indebted as Clinical Psychology is to Wechsler for a sensible test of adult intelligence and for his reasonable management of the problems of comparison of adults for brightness, there are two features of the test which are notably weak. First is the grossly inadequate standardization population for persons in the age group of fifty and over. Equally and avoidably missing are norms for various large American ethnic groups. Secondly, there is something awry with the so-called "deterioration index"—an attempt to incorporate in test norms an age differential which makes aging less damning because it happens to everyone. Far too numerous are the instances where the "deterioration index" shows nothing. Often the existence of depression and intrapsychic preoccupation are sufficient to yield a high "deterioration index" which is disturbing in view of the connotation of that word and the possible transient nature of depressed and preoccupied states. Wechsler's index sometimes confuses impairment of mental energy with deterioration. But there is something more than semantically wrong with his formulation of the problem which will have to be worked out by more careful sampling procedures—especially in the old age groups as already noted.

If clinical psychology can make advances in techniques for assessing brain damage by careful assessment of what psychological functions remain intact, impaired, or absent after lesions or destruction in various brain areas, these will be eagerly received. The crude but often correct knowledge obtainable from the Goldstein-Scheerer, Bender Gestalt and similar tests of per-

ceptual and conceptual functioning should be refined by the development of other and more quantitatively sensitive tests which also systematically explore other areas of sensation and discrimination.

Incidentally the task of adequately standardizing psychological tests is far more than a one-man job. Test construction and standardization involve for psychologists matters of public trust—like tables of weights and measures. If psychologists want their pronouncements to be taken seriously and are prepared to stake their reputation on the interpretation of scores obtained from tests, they should carefully scrutinize the available materials—however neatly they are packaged and advertised. There should be some way to finance a factorial analysis of test items with a view to their refinement, and to guarantee representative sampling and adequate standardization of a new test. If a new profession's reputation in part depends upon the goodness of its instruments there should be group rather than individual responsibility for them. The appearance of Form II of the Wechsler test with insufficient standardization norms is a case in point.

2. The Rorschach Test

Of the two most widely used projective techniques, the Rorschach has more value in a mental hospital. These ink blots are a truly remarkable instrument for penetrating the silent nature of mind which underlies that consciousness about which we are sporadically knowing. The nature of mind as an entity apart from its characteristic productions is not readily studied—even when persons are willing to answer all questions. From the Rorschach one obtains cues as to how a mind works: how effectively, how uniquely, how concertedly and with emotional material, how the mind deals with anxiety, or with pleasurable stimulation, and so on. The perceptual and affective processes are assessed—and perhaps to a lesser extent the cognitive and connative. It is

unexcelled for reporting on the state of a mind at any given moment. Conversely the Thematic Apperception Test provides the best cues for studying the hidden or hurting contents of mind, over a spread time and it is remarkable how neatly these two procedures supplement each other.

Again it is assumed that literate persons interested in the Rorschach method will read the basic monograph of Hermann Rorschach and the later studies of Beck, and Klopfer and Kelley as well as sample the extensive periodical literature. Here there is place for no more than a few unrelated ideas about interpretation and the development of a working competence with the Rorschach materials.

In ink blots, like clouds, can be seen so many things that to specify the range and frequency is an enormous task. Steadily an approximation to norms of this sort is being achieved while analysis of the determinants of percepts is being experimentally refined. But against the sheer additive management of percepts and "determinants," it is useful to remember that the same percept maybe singled out for different reasons. For example, one subject may see—say, flowers as a primary percept, while another sees them as a "defense" against some other unwelcome percept. Then it is sometimes possible to follow a person's flight from a percept disturbing to him to a safe percept, with or without some poor form responses in between. Some can achieve what appears to be a safe response, others become silent, others leap desparately from one disquieting image to another, but the point is the *sequence* of responses is a determinant of the percepts—i.e. the first response may elicit ego defenses that determine the next three or four responses and even have continued effects on all following cards.

Apropos of the same example, while Rorschach stated that it was extraordinarily rare to obtain emotionally charged responses of the sort indicating "unconscious complexes," our ex-

perience is quite the reverse. And while it is easy to agree with him that there are better ways to delve into the unconscious, still one should not throw away something good because there is something better. The "content" of responses may sometimes be meaningfully interpreted, but, on the other hand, one should guard against oversimplified attempts to delimit one-to-one meanings. For example, that the response to card four indicates one's reactions to one's father, or that plate four projected as a "stump" necessarily signifies impotence.

It is indeed extraordinary what a skillful Rorschach analyst can say about personality from protocol, but it is as remarkable that we have not proceeded apace in explaining or understanding the processes involved. The inferential process should be explained as well as the dynamics of perception but neither the elaboration of little ratios nor the generalizations of some bold exponents seem yet adequate. While it is incumbent on experts who place themselves in the role of teachers to make explicit the processes by which they make their deductions, there is a hazard in this situation. The pressure to communicate one's insights by a formalized system of analysis may force one with good intuitive skills into the fabrication of a defective system. Far from instructing, the system may misdirect and also leave a gifted intuitive person with a system he feels obliged to defend. This has happened repeatedly in the history of graphology. Perhaps it is possible to communicate skills without actually talking at the level of the grammarian: by imitation and emulation one can learn from one who knows—hence the value of working with persons who have had a broad range of experience with such materials as the so-called projective tests.

As with all other skills, one learns by observing, remembering and relating until one has developed a "frame of reference." When this is achieved the practitioner may be elated that he can venture hypotheses about character and have these confirmed,

but it is necessary to remind one's self that it is after all peculiar to extrapolate from a primarily perceptual task notions about non-perceptual processes like motivation. One should beware of the processes of extra inference whereby one can be grandly wrong.

3. The Thematic Apperception Test

This test consists of a set of pictures, ambiguous for meaning, relationships between persons depicted, and implications for action. They provide an intriguing fund of material by the simple expedient of asking a person to tell an imaginative story, indicating who the people in the picture are, what's going on, what led up to it, and what is the outcome.

In lieu of norms for this test, Dr. Murray has provided an elaborate schema for the analysis of mental content and motivation which should be read by all students of personality. Scoring schemes for analyzing the content of stories into motivational units, simple and complex, are cumbersome but rewarding. This roughly characterizes the analysis proposed by Dr. Tompkins and also that of Dr. William E. Henry. While not eschewing these approaches which require sustained analytical attention to protocol, a well-founded analogy has encouraged a more intuitive handling of the material recommended in some instances.

It is argued that the stories told are like dreams and day-dreams in these particulars. There is vague material presented that has objective stimulus value. The subject is almost literally asked to "dream it up." As in the dream, so in the stories the self is rarely absent. Wishes may underlay the stories elaborated. The person may be more or less critical or take more or less pleasure of his own phantasies.

If the analogy is well taken, then it follows that one can learn much about the analysis of TAT stories from dream analysis. No one has argued to the contrary, yet the point is worth making

because it seems possible that systematic counting practices can result in a distorted portrait of a person who—say, has complicated his stories by the device of “distributive identification,” or “representation by the opposite” or who overtly tells not the story but a “secondary elaboration” of the thoughts which occurred to him on viewing a stimulus card. If one is familiar with the language of the dream, it becomes possible to explore TAT protocol with more insight—and simultaneously—it is to be hoped—more caution, since the universal penchant for projection should be plainer. Thus, if one can add to the process of breaking down stories and sorting their fragments, a flair for the level of intuitive thinking needed to understand the daydream and dream, the resulting synthesis of character will be truer.

With mental patients, things apperceived and related about pictures are often transparently autobiographical, sometimes at a deep level of consciousness. From persons unread and un-conversant with psychoanalytic formulations time and again are recorded stories that are classic and complete in detail. The son or someone has shot the father, the boy will come back to mother, spend the rest of his days taking care of her; they will live happily ever after. Or from the female patients the counterpart: every picture of a man and woman suggests father and daughter. Opposed to this intimacy are elements of hostility and guilt which accompany percepts of two women together—especially an older and younger woman. Characteristically major conflicts and psychological trauma, real or fancied, project themselves into stories: ambivalences, depressive and suicidal trends, fusions of sexual desires, unadulterated death wishes with or without retribution and so on. It is necessary to point out that whereas the material abstracted from the stories may be true, it does not of necessity explain why the person became ill, or it is not all of equal relevance in the etiologic picture. For example, if a patient produces a thickly Oedipal story, it does

not follow that he is mentally sick because of it. Many are not, although these same people may yet be sick over problems about their sexual role. How much striving, opposition, and aggression is permissive for them. There are common themes in the stories of mental patients, but whether these are correlates or causes or consequences of mental illness remains to be established.

One additional interpretative comment which may prove interesting to those who have not already considered it: perhaps what is left unmentioned or unsaid about a picture that has, after all, some degree of structuredness, is as legitimate material for interpretation as what is commented upon or incorporated into a story. One can ask why is it a person does not see something obvious. Sometimes inferences about suppression or repression are warranted.

While the Rorschach test usually provides material which reflects the momentary and conceivably atypical and transient state of the person, the Thematic Apperception Test gives material compounded of past, present, and future. Ambiguity begets ambiguity and it is often difficult to parcel out the pathogenic present from the past perverse. This caution cannot be overstressed. Personal projection in weighing the material is like a whirlpool into which inevitably are sucked all who have not deep self-knowledge.

A further simple device very useful in providing hypotheses about a person's perception and feeling for his body and its parts is a drawing of a man or woman—or both if the individual will cooperate. Features of the drawing receiving excessive elaboration, or avoidance, enlargement or reduction, mutilation, and the like—these are often reliable cues regarding the "body image," and what aches, angers, cuts to the quick. It is noteworthy that paranoid trends can often be discerned from a person's drawing of the eyes as compared to the rest of the figure; but why this is so remains conjectural. True, one looks at others

and they at the self with eyes, but paranoid delusions often involve hearing voices, and our observations, while not systematic, fail to show a correspondingly exaggerated focus on ears.

One develops a set of hypotheses regarding aspects of body drawings which are expressive of personality by considering these products in relation to other diagnostic tests. Congruent and discrepant impressions are noted until one presently can venture something of a character analysis from the drawings, and later check it by other tests of personality. In a similar manner each one for himself can learn what he wants to about character analysis from handwriting. In these matters self-instruction is recommended for two reasons. First, the incredulous can see for themselves "if there is something in it." Secondly, as mentioned earlier, there is a species of knowing which is yet beyond the communicative capacity of systematizers. One will not find in graphological systems the indices of compulsiveness, narcissism, ambivalence for the self, impulsivity, duplicity and bisexuality which this writer uses but by forced guessing, proceeding in trial and error fashion, one can educate oneself to be intuitively far more adept than is consistent with psychology's claims to scientific rigorousness. If one can be intuitive and right,—why not?—providing one does not abjure statements regarding the confidence level with which one guesses, and providing one can resist the airs of "seer" and crystal-gazer.

This introduces the question: How does one develop clinical skill? Perhaps some of these ideas may prove useful to inquiring minds.

IV. How To Develop Skills As A Clinical Psychologist

A. Routine Practice in Testing

It is impossible not to sound pompous when the obvious has to be said. Persons interested in becoming skilled should practice. Routinely they should give more than one test and ponder

the congruences and differences in performance which emerge, and their meaning for psychological functioning.

B. All Sources of Information Checked

Then, after analyzing test data and formally writing a summary assessment of all aspects of the total personality which they can infer from the tests, together with a "confidence level" index for each inference—when this is done, *then*, all possible sources of information should be checked. Sources such as case records, social service histories, psychiatrist's formal summaries or informal conversations regarding the person, attendants' and nurses' impressions—in short, any factual or impressionistic data with which to confirmatively or correctively check one's summary should be eagerly but unobtrusively sought.

C. Not a Mere Psychiatric Confirmation

In clinical practice it is good policy to make studies of personality independently of psychiatric diagnoses and case records—otherwise one's work is liable to be regarded as no more than rubber stamping of dubious beaurocratic requiredness. Respect for psychological tools is gained when psychologists can independently extrapolate relevant and pertinent summaries from their tests and this without recourse to interviewing the patient while testing. Not only is the value of an independent assessment of personality lost by abrogating the above injunctions, but a working relationship with psychiatrists is disturbed. Their esteem for the acuteness of psychological tests and the astuteness of psychologists is diminished in proportion as they pre-inform us that they have a patient of X-type to be tested and get back nothing further than a report that the patient "tested" is an X-type.

D. Need of a Definite Report

The responsibility for undersigning something in print about another person is at once sobering and stimulating. It is good

experience as well as justice to have more than the reputation of the patient hang on a psychologist's report. It encourages responsible thinking and thinking in terms of degrees of confidence one can attach to statements. Some practitioners become verbose or vague or both and are vexing to other professionals in mental hospitals. To sound like a long-winded vending-machine-characterologist without even the slightest factual gratuity—an index of height, weight, or a piece of gum!—is inexcusable. There is great merit in brevity: people will read and can remember what is said briefly. The goal, however, is not brevity but aptness—the apt characterization of a total personality, not as a work of art but as a set of statements with valid historic and predicative value regarding likely behaviors from the individual.

E. Alertness to Value of "Blind Diagnosis"

As the above is effective experience for one's public professional performance, so practice at so-called "blind diagnosis" is valuable for private training. Working exclusively from test results, without having seen the patient, with the aim of writing from such materials a thumb-nail sketch of the person, is a fascinating and instructive exercise. Given a person's protocol from the Rorschach and Thematic Apperception Tests with the task of writing an idiographic and verifiable description of an unknown person, can one do it? More than an exercise in inference, this provides an opportunity to learn how good one's instruments are, and how good one's self is as an instrument. Also, it suggests how much reliance is made on non-test data, that is, influences and impressions from face-to-face confrontation. Practice of this sort can simultaneously teach confidence and caution, an attitude of sensitive curiosity and sensible humility. If the mind has a tendency to project, one has an opportunity to learn wherein and to what extent, and thus sensing the fallibility of one's mind as a measuring device and appraised of constant

error, be set to correct errors of perception and inference when confronted with comparable material another time.

F. Interprofessional Confidence

Again, the problem of interprofessional confidence arises, and respect for psychological tools is enhanced in so far as psychologists can produce verifiable information from tests without other data. It is paradoxical that psychologists are on the defensive regarding projective techniques since the two major devices come from men trained in the medical and psychiatric tradition. But it is equally disquieting to hear psychologists waxing arrogant because they with these devices can be more quickly discerning than psychiatrists not trained to use them. After all, the person working with the mental patient sees the latter as he is, and it is from this state that he must work. Sometimes a psychologist's extrapolations are true but spread over the life span, they are confusing in respect to the time element, the unconscious, reality, potentiality and phantasy. The challenge to provide useful usable information often goes unrecognized.

G. Understanding an Artist's Production

Another and perhaps neglected source of training in insight and understanding of character is to be found in artists' productions. It may be regarded as Philistinism to recommend the careful inspection of works of art as a means to some end other than esthetic experience; but the aim of personal growth is not foreign to the language of art appreciation. In any case some artists are gifted with an ability to create character. By a judicious juxtaposition or summation of symbolically crystallized essences they imbue words or lines and colors with life. By comparison characters delineated by most psychologists are scarecrows. From many novelists we have much to learn and from their novels. Persons and actions are often perplexing in novels as in reality

—although somehow not in psychological reports which easily resolve all enigmas! This is material for rumination. Then there is the possibility of regarding the characters and action in a literary piece at least in part as derived from the personality of the author, and hence as material through which one may achieve some understanding of his personality. One can learn something of style and character and art and genius by reading and contemplating writers like Dostoyevsky, Hardy, Strindberg, Mann, Schnitzler, Proust, Henry James, and, of course, others. Also there is an entire literature of personal documents: memoirs, diaries, confessions, autobiographies and letters. Incidentally, the latter are a comparatively neglected and completely fascinating source of information on character, giving insight into the range and congruity of a person's "social selves" often unwittingly concealed in consciously autobiographical efforts. Comparable gains may be achieved from the sympathetic study of visual art. Surely psychologists who make so much of a few pictures and ink blots should be willing to look long at other pictures, many more provocative than those we deal with.

H. Wide Experience in Social Types

Because many things cannot be learned vicariously, a large life experience, with a broad range of people and roles, is recommended. In so far as character runs to types, an acquaintance with thieves, toughs, tavern boys, ambitious men, ascetics, alcoholics, sinners, social climbers, salesmen, and the like, along with their male and female counterparts,—such acquaintances are valuable in minimizing naive and narcissistic evaluations of others. Experience in a wide range of social and economic and interpersonal roles also broadens one's empathic scope. Both wide experience with people and roles are valuable aids to rapport and insight.

I. Acquaintance With Psychoanalysis

Finally, there is nothing better for the development of skill and understanding in the use of projective tests than an experience comparable to if not identical with a therapeutic psychoanalysis. In addition to sharpening insight and general knowledge of mental functioning, in so far as the issue of who is permitted to practice psychotherapy is settled in terms of competence rather than license or prerogative, psychologists will be better qualified to use themselves as therapeutic instruments after analysis.

ADDENDA

The following books, each in its own way, substantially fulfill some critical gap hinted at and are therefore specially noteworthy.

ANASTASI and FOLEY have provided much useful data on ethnic comparisons involving tests. Machover has provided a brilliant exposition of character analysis from drawings of the human figure. And Schafer has done a first-rate piece of work on the comparative, analytic and synthesizing attitude as applied to several tests from a single subject.

ANASTASI, ANNE AND FOLEY, JOHN P.: *Differential Psychology*, (Rev. ed.) New York, Macmillan, 1949.

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SCHAFER, ROY: *The Clinical Application of Psychological Tests*, New York, International Universities Press, 1948.

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ABNORMALITIES OF INTELLECT

By

LILLIAN G. PORTENIER, Ph.D., Psychologist
University of Wyoming, Laramie, Wyoming

Chapter XI

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University of Wyoming, Laramie, Wyoming

I. Meaning and Classification of Intelligence

Intelligence is revealed by human or animal behavior; in specific, it is identified with an individual's capacity to make use of what he has learned from past experience in adjusting to new situations. Stern¹ defined intelligence as "a general capacity of an individual consciously to adjust his thinking to new problems and conditions of life." Stoddard's² definition includes, perhaps, the principal attributes of intelligence as the term is used at the present time. He defines intelligence as "the ability to undertake activities that are characterized by (1) difficulty (hard task), (2) complexity (number and kind of tasks attempted), (3) abstractness (symbolic relationships), (4) economy (speed), (5) adaptiveness to a goal (purposeful behavior), (6) social value (socially approved), and (7) the emergence of originals (new ideas), and to maintain such activities under conditions that demand a concentration of energy and a resistance to emotional force."

A great step forward was taken when psychologists began to differentiate degrees of intelligence by means of quantitative measurements. The progress made has been compared to that

achieved by physicists in designating colors by wave lengths instead of by their hues. The measure of mental ability most commonly used is the intelligence quotient (I.Q.), which is computed by dividing a subject's mental age (M.A.), as determined from a standardized test, by his chronological age (C.A.). Under ordinary circumstances the I.Q. of an individual remains relatively constant throughout life. The great value of the I.Q. thus is that it furnishes a method of defining the relative intelligence of an individual more or less permanently.

People differ widely in intelligence, ranging from the mentally gifted to the feeble-minded. The differences are marked not only in amount but in kind as well. If measurements are taken of the achievement of a large random sampling of individuals involving almost any aspect of intelligence, memory, reasoning ability, speed, et cetera, it will be discovered that the resulting scores may be distributed into what is commonly known as a normal probability curve, or a frequency distribution. The large majority of the scores tend to cluster at or near the center, with a smaller percentage on either side gradually sloping off to a few very exceptionally high scores at the extreme right; and to approximately the same number of low scores on the extreme left. While there is little difficulty in determining the range and the mean score for such a distribution, the frequency curve is continuous, there are no sharp breaks in the distribution of scores. Consequently, the exact points of division used in classifying various levels of ability are arbitrary.

Terman's³ classification which has been widely employed is given in Table 1. In arranging his various I.Q. classifications he has arbitrarily used figures with zero as the limiting cipher for each new class. For example, persons earning I.Q.'s from 90-110 are considered average, those with I.Q.'s less than 70 are designated as feeble-minded while those with I.Q.'s of 120 and above are very superior.

TABLE 1.
Classification of Intelligence According to Terman

<i>Classification</i>	<i>I.Q.</i>	<i>Per Cent Included</i>
Genius or near genius	above 140	0.25
Very Superior	120-140	6.75
Superior	110-120	13.00
Average (normal)	90-110	60.00
Dull normal (backward)	80- 90	13.00
Dull (borderline)	70- 80	6.00
Feeble-minded	below 70	1.00
Morons (mental age of 8-10 years)	50- 70	0.75
Imbeciles (mental age of 3-7 years)	25- 50	0.19
Idiots (mental age of 2 or below)	below 25	0.06

As already noted the precise limits of these classifications are arbitrary and artificial. Not all workers have used identically the same limits in classifying levels of intelligence. Wechsler⁴ used as the basis of his classificatory scheme a definition of intelligence levels in terms of statistical frequencies. Each intelligence level is defined as a class interval embracing a range of I.Q.'s falling at distances expressed as multiples of the probable error (P.E.). Thus mental defectives are defined as those whose scores are three or more P.E. below the mean, while persons whose scores are three or more P.E. above the mean are designated as very superior.

It should also be kept in mind that the absolute value of an I.Q. is a purely arbitrary number. The numerical value has no more fixed meaning than a passing mark on a scholastic examination. By general agreement the dividing line between persons who are designated as average (normal) and those who are below average (below normal) is the deviation—1 P.E. On the normal probability curve the middle 50 per cent of the group is defined by a range extending from + 1 P.E. to — 1 P.E. deviation from

the mean. An average person then would be any individual who falls within the middle group of individuals. Wechsler equated the distance—1 P.E. against the I.Q. of 90 and in so doing defined not only this particular I.Q. but all other I.Q.'s as well. Wechsler's classification of intelligence is shown in Table 2.

TABLE 2.
Classification of Intelligence According to Wechsler⁴.

<i>Classification</i>	<i>I.Q. Limits</i>	<i>P.E. Limits</i>	<i>Per Cent Included</i>
Very Superior	.128 and over	+3 P.E. and over	2.2
Superior	120-127	+2 P.E. to +3 P.E.	6.7
Bright Normal.	111-119	+1 P.E. to +2 P.E.	16.1
Average	91-110	-1 P.E. to +1 P.E.	50.0
Dull Normal ..	80- 90	-1 P.E. to -2 P.E.	16.1
Borderline ...	66- 79	-2 P.E. to -3 P.E.	6.7
Defective	65 and below	-3 P.E. and below	2.2

In comparing Tables 1 and 2 some disagreement in I.Q. limits for the various intelligence levels will be noted, and there is also a slight difference in the per cent of individuals included in each class. These differences may be accounted for in part by the different methods used by the two workers in determining the I.Q.'s and the I.Q. limits. However, other major factors to which the differences may be attributed are the fact that the tests used do not measure identical abilities, and to the widely differing samples of the population studied. Terman administered the Stanford Revision of the Binet Test to 1000 school children ranging in age from 5 to 14 whereas the results on the Wechsler-Bellevue Intelligence Scale administered to about 1000 subjects ranging in age from 10 to 60 were used by Wechsler. The Stanford Revision is primarily a verbal test, while one-half of the items in the Bellevue Scale are non-verbal.

The Wechsler-Bellevue Scale was first published in 1939, hence

most of the studies cited throughout this discussion are based on the Stanford Revision using Terman's classification. Nevertheless, the samplings of population which will be discussed are far more comparable to Wechsler's sampling and the abilities considered are more similar to those measured by the Wechsler-Bellevue tests. The latter scale is better suited for use with adults, particularly those who are functioning at different levels in the various capacities comprising general intelligence.

In the tables cited, the average or normal population comprises from 50 to 60 per cent of the population. Of the remaining 40 to 50 per cent many are only slightly above average or mildly defective and will receive little attention in our treatment of the abnormal. While these classifications were based entirely on intelligence, other factors such as health, personality, and physical defects, enter into the functioning level of mental ability and should receive due consideration. On these bases abnormalities of intellect will be considered under three principal headings; *Mental Deficiency*, *Mental Disorganization and Deterioration*, and *Mental Superiority*.

II. Mental Deficiency

A. Definition

Mental deficiency, or feeble-mindedness as it is popularly known, is a condition in which the individual shows no peculiar departure from the normal in intelligent behavior, as is generally true in cases of dementia, but rather is a condition in which he has less than the normal or average amount of intellectual capacity. It is characterized by limited capacity for mental development. The term *amentia*, or lack of mental ability, is also used to describe the condition in contrast to *dementia*, loss of mental ability.

Prior to the use of tests, intelligence was defined chiefly in terms of the individual's ability to adjust socially. A mental

defective was defined as a person who "through congenital arrest or imperfect mental development was incapable of managing himself or his affairs with ordinary prudence." This practice was commendable in that it called for observations of the practical adaptability of children and adults to social living but such definitions were subject to many different interpretations. The advent of intelligence tests has made the estimation of mental ability far more precise. The use of test scores has made possible the prediction of certain kinds of behavior within broad limits with a reasonable degree of validity.

Although an I.Q. of 70 has been used most commonly in the United States as the upper boundary for mental deficiency, Kuhlman⁵ used 75 and Wechsler 65. In England, too, it has been customary to designate as feeble-minded all persons with I.Q.'s below 75. It must be remembered, nevertheless, that identical I.Q.'s on the different tests may well represent very different orders of intelligence. An I.Q. of 70 on a non-verbal test is not necessarily equivalent to an I.Q. of 70 on a verbal test. It is also decidedly risky to consider any two verbal tests as exactly equivalent. The concept of feeble-mindedness is essentially social. There is grave danger of making a diagnosis on the basis of an I.Q. alone. The I.Q. is not sufficient for a thorough understanding of the basic psychological behavior. One feeble-minded person may be wholly inadequate in adjusting himself to society, while another with the same I.Q. may make a highly satisfactory adjustment. Many higher type mental defectives make good adjustments, and with proper guidance become useful, and respected citizens. Personality characteristics, training, and circumstances must be considered along with the I.Q. in determining a person's ability to adjust socially and to manage his own affairs with ordinary prudence.

Wechsler⁴ emphasized the fact that the concept of mental deficiency is far from a simple entity. He states, "There are at

least two and probably three types of mental deficiency. The first is the intellectual defective, diagnosable as such by the usual psychometric tests; the second, the social defective for whom the life history of the individual is the most satisfactory criterion; and, third—the emotional or “moral” defective whose precise definition is extremely difficult to give, but whose existence, to anyone who has had any first hand experience at a large clinic, is an observable reality. Between all three there is usually a certain degree of correlation, but this correlation is not sufficiently high to make any one an unfailing diagnostic indicator of the other.”

B. Incidence

Since no clear line of demarcation can be drawn between the mentally deficient and borderline cases, and since various investigators have used different points on the frequency distribution as the dividing line, no definite figures can be given to indicate the number of feeble-minded in the population. The problem is further complicated by the use of social or economic criteria of intelligence by those whose aims are practical. Consequently, the incidence of mental deficiency is dependent upon the criteria employed.

Any figures which may be cited are dependent also upon the age group studied. The mortality rate among defective infants and children is much higher than for normal children of the same age. Several studies have shown at least five per cent of children under two years of age to be mentally defective. The percentage decreases to about one-half this number for grade school children⁶ and to approximately one per cent for the adult population. An estimate of over one and one-half million mental defectives in the United States would seem justified on the basis of many recent city, county and state surveys. Comparable figures are not available for other countries due primarily to the

fact that no measuring instruments are available which are equally valid for different groups with their widely varying environmental backgrounds that race prejudice has helped to create. Undoubtedly the percentage is fully as large in most countries as in the United States, perhaps even larger in certain more primitive cultures. Data compiled for racial groups in the United States show a larger percentage of mental defectives for the Indian and the Negro population than for the Whites. It is difficult to determine how much of this difference should be attributed to the marked educational handicap suffered by these groups.

C. General Characteristics

Scientific studies of the relationship between physical traits and level of mentality have yielded results in variance with popular assumptions, and the experimental findings have not been wholly unambiguous. Excluding the major clinical varieties, it appears that mental defectives are physically somewhat inferior to the average person in weight and stature. Most of the differences found, however, have not proved statistically reliable and are too small to be of any significance in predicting intelligence. Practically all degrees of height and weight are associated with low mentality. Aments (mentally defectives) approach the norm more nearly physically than mentally. Deficiencies in weight and skeletal growth can be explained on the basis of poor environment and inferior hygiene.

Talking and walking are frequently delayed in mentally defective children. Their motor coordination is often poor and speech defects are common. As a group they have more physical deviations than the average person.

Burke⁷ found a greater frequency of such defects as cleft palate, harelip, distortions of tooth growth, and webbed toes and fingers. The physical defects are generalized rather than localized, and are an indication of a general biological deficiency which

will naturally produce a large number of physical defects and stigmata. In rare instances only have extensive neurological defects been found in the brains of mentally defective individuals. Excessive absence from school due to illness has been reported for the feeble-minded, and their mortality rate is high.

Speech defects are sufficiently common among the feeble-minded to be of major importance in clinical diagnosis. Speech impediments tend to increase with decrease in mentality. Defects of pronunciation are marked and occur most commonly in the consonants. Impairment in speech is attributable to imperfect coordination of the speech mechanism or to an inability to perceive and to discriminate between slight differences in auditory sensations.

Low mentality is most commonly found in families of low socio-economic status. Less than one-half of the feeble-minded are self-supporting, however, with adequate guidance and training many more might become economically independent. About ten per cent of these are cared for in institutions for the feeble-minded and many more are cared for in correctional institutions, homes for the indigent, almshouses, or by their own families. As children mental defectives require an undue amount of assistance in feeding and dressing and many of them continue to be dependent upon society for support and management as adults. They lack social competence and are more susceptible to personality and social maladjustments than are average persons. Without careful training and supervision they tend to become destructive, antisocial and immoral. Those who are stable tend to be inoffensive, colorless, cheerful and obedient, but a fairly large group are unstable, asocial, ill behaved and excitable.

In addition to the quantitative differences determined by psychological tests mental defectives are characterized also by the quality of their responses. Their memory span is limited, they fail to detect absurdities in statements, and it is difficult to

arouse and hold their attention. This is evidenced by their special difficulty in repeating digits. Wechsler found that "except in cases of special defects or organic disease, adults who cannot retain 5 digits forward and 3 backwards will be found in nine cases out of ten to be feeble-minded." He found the Digit Span Test one of the best in his battery for picking out mental defectives. The Picture Completion Test in the Wechsler scale which measures the ability of the subject to differentiate essential from unessential details is also very good for testing intelligence at the lower levels. Aments are easily distracted, have limited powers of reasoning, and little creative ability. Their abilities tend to be concrete rather than abstract, and they are very restricted in imagination, curiosity, and initiative. They are unable to coordinate two or more mental functions and have difficulty in assimilation. Their appreciation of intellectual humor is lacking and their reaction time is slow.

A satisfactory diagnosis of mental deficiency, consequently, calls for the following essential attributes; constitutional deficiency, developmental arrest, social incompetence and intellectual retardation.

D. Etiological Factors

Perhaps no problem in the field of abnormal psychology has attracted wider attention and aroused more heated debate by laymen and scientists alike than that dealing with the basic cause of feeble-mindedness. It has been a moot question during the past century and continues to stimulate study for serious students perennially. On the one hand are those who hold that all mental deficiency is determined by hereditary predisposition, and on the other hand are the ardent advocates of the theory of environmental circumstances who emphasize economic, educational and other social inequalities. Parental alcoholism; syphilis; birth injuries; acute infectious or inflammatory diseases, especially early

in life; convulsions; brain tumors; malnutrition, in particular vitamin deficiency; endocrine disturbances; the Rh factor in the blood; and countless other causes which have not been verified have been advanced. For example, Clark⁸ postulates the theory that some mental deficiency is due to early emotional repression, and that the condition might be improved by removing the emotional blocking through psychoanalysis. A large number of cases are the result of the interaction of two or more contributory factors.

On the basis of the nature of the fundamental etiology Tredgold⁹ has grouped the causal factors of mental deficiency into two general classes which he has designated as the *primary* and the *secondary*. All cases basically due to some inherent germ impairment are classed as primary, *native*, or *endogenous*. Eighty per cent of all cases of amentia fall into this group. About 75 per cent of these cases have no distinguishing physical characteristics. They are designated as cases of simple, primary amentia. The remaining 20 per cent are classed as secondary, *acquired* or *exogenous* mental deficiency. This group includes all cases for which the cause seems to be an outside influence of some sort, such as glandular deficiency, a disease, or an injury which interferes with the normal mental development.

Hollingworth¹⁰ has summarized some of the most significant facts concerning the feeble-minded as follows:

1. Feeble-mindedness represents a developmental status, rather than a disease, or a distinction of species, or a qualitatively distinct picture.
2. Degree of mindedness is represented by continuous gradations along a scale of measurement, rather than by discrete groups or classes.
3. Feebleness of mind occurs on a background of constitutionality or heredity, for the most part determined by factors over which we have but little systematic control.

4. The condition is systemic or organismic; it is a general inferiority, not merely inadequacy of some one or more powers or faculties.
5. Although general it is also differential, that is, not equally marked in respect to all characteristics.
6. The differential picture is not a random one, but occurs according to a set of definite principles, or laws, not unrelated to the general laws of human diversity.
7. Similar differences are to be found between adjacent groups at any point along the scale of measurement. Individuals of I.Q. 150 and 130 differ as do those of 130 and 100, or 100 and 70, or 70 and 20.
8. The most conspicuous lack in the feeble-minded is incapacity for symbolism. This is often called inadequate learning ability, and depends on relative inaptitude for redintegrative activity.

E. Degree of Deficiency

From the standpoint of degree three classes of feeble-mindedness are commonly distinguished; morons, imbeciles, and idiots. This division is somewhat arbitrary since there is no sharp line of demarcation, as previously noted above the curve of intelligence is continuous.

1. Morons

The highest of the three general types of defectives are termed morons. This group constitutes about 75 per cent of all feeble-minded. As a group they range in I.Q. from 50 to 70, i.e., those at the lower limit attain about 50 per cent normal mental growth. The adult moron has a mental age of from 7 to 9 years.

Most morons learn to read and write but are limited to simple concrete facts, abstract concepts are very difficult or impossible. They seldom progress beyond the fifth grade even when required

to remain in school to age 15 or 16. Special class training is recommended. With careful training and patience morons may become proficient in simple semi-skilled labor, such as care of animals, farm and factory work, general housework, laundry, canning and plain sewing.¹¹ Under favorable circumstances they may become partially or entirely self-supporting but they are not infrequently irresponsible and lacking in judgment. Superior home background, careful training, and stability in personality are factors essential to success.

2. *Imbeciles*

About 20 per cent of mental defectives are in the intermediate group classed as imbeciles. They range in mental age from about 3 to 7 years and from 20 or 25 to 50 in I.Q. Most imbeciles profit little from special class training. The language for some is limited to short phrases. The lower types require permanent care in special training schools or institutions. They must be closely supervised to avoid harm to themselves and their companions. If physically sound they can attend to their own bodily needs, guard themselves against fire and falling down stairs, and they can be trained to run errands, sweep floors, feed animals, and do other simple unskilled tasks, but they are usually unable to carry them on independently.

3. *Idiots*

Idiocy is the lowest grade of amentia. About five per cent of the feeble-minded fall in this group. Even when their mental development is completed they have a mental age of less than three years, an I.Q. below 25. They are never able to care for their personal needs and their speech is restricted to a few simple words or sounds. They must continually be guarded against physical danger and seldom master even the simplest tasks. Some are more helpless than the lowest animals. Their prolonged in-

fancy necessitates constant individual attention and care which is most adequately provided in custodial institutions. Since he resembles a human being but shows few of the behaviorial characteristics we think of as human the idiot all too often is surrounded with an air of mystery. It is not surprising that primitive people should develop a supernatural view of his origin. In some cultures they were even revered as pure-hearted children of God, untouched by the evil world.

4. *Idiots Savant*

An extremely rare type of ament is designated as an idiot savant. The term is used in referring to mental defectives with some ability which is exceptional in comparison to his defects. The term is misleading since they are seldom if ever either idiots or savants. Their mental level is usually that of an imbecile or a moron and some appear to be cases of dementia rather than amentia. Their special ability is rarely above the average for normal individuals and is ordinarily restricted to one special field. Cases which have been recorded include special musical talent; ability in drawing, or in painting; mechanical aptitude; proficiency in arithmetic, in most cases in a limited skill only; and phenomenal memory, which has not always been general, in some cases very limited, although in several instances the cases were inmates of institutions and the available data are inadequate to determine the level of mentality. They may have been socially inefficient, but not mentally defective. Recent cases which have been studied disclose a few in which some special talent, or high degree of skill has been combined with low verbal intelligence.

F. Clinical Varieties

While mental defectives as a group tend to exhibit more physical anomalies than normal persons the large majority present no

distinct morphological picture. At least 80 per cent cannot be distinguished from normal individuals on the basis of appearance by casual observation. This finding disproves the early medical conception which held that feeble-mindedness was revealed by abnormal physical as well as mental symptoms. The error in this conception was recognized by Shakespeare as indicated by the following quotation from Macbeth:

"There is no art to find the mind's construction in the face."

There are, however, a number of clinical varieties, or types, who in addition to being extremely low in general mental endowments also have physical stigmata so marked that they can be recognized by the uninitiated. Their feeble-mindedness appears to be caused by factors that also produce physical stigmata. While some cases of simple amentia (morons, imbeciles, and idiots) may be attributed to congenital disturbances, the majority may be classed as primary, or endogenous mental defectives in that they seem to lack the hereditary potentialities necessary for normal mental development. In contrast to this group most of the clinical varieties appear to be cases of secondary, acquired, or exogenous mental deficiency. In so far as medical science has been able to determine they seem to be caused by some outside influence such as a glandular deficiency, a disease, or an injury. Some cases are mixed forms in which some outside disturbance is superimposed upon a constitutional deficiency.

Among the clinical varieties the types which are sufficiently frequent and important to merit special consideration are the *cretins*, *mongolians*, *microcephalics*, and *hydrocephalics*.

1. *Cretinism*

The condition known as cretinism constitutes from three to five per cent of institutionalized defectives. It invariably results from hypothyroidism, i.e. deficiency of thyroid activity. The infant fails to show normal physical development. Cretins are

most readily distinguished by their dwarfish stature, and by their characteristic facial expression. They have short thick legs and arms, short stubby fingers, infantile bodily proportions and a protuberant stomach. The head is frequently large, the neck thick and short, features coarse and the skin which hangs in folds is dry, rough and sallow. The eyes are widely separated with swollen eyelids, the nose flattened, lips thick, and the tongue large and clumsy often protruding from a partly open mouth. This results in a dull, listless, docile expression. Some develop to only three feet in height at maturity. They tend to be very sluggish, and are delayed in sitting and standing. They often begin walking as late as the fourth or fifth year and then only with a slow waddling gait. Their bodily balance is unsteady and all movements are characterized by clumsiness. Puberty is delayed and in males the testes may not descend.

Mentally there is pronounced general impairment of intellectual and emotional faculties.¹² All degrees of backwardness are found with the majority classifying as idiots or imbeciles. They show little initiative and motivation, and have difficulty in concentrating. Speech is delayed, frequently appearing as late as the seventh or eighth year when it is indistinct and limited. Most cretins are affectionate, good-natured, and harmless and cause less trouble than most other types of defectives, though a fairly large number have personality disturbances ranging from mild depression and irritability to compulsive and hallucinatory reactions.

No brain lesions have been found, but growth and development of the brain are affected along with other portions of the body. Post-mortems have shown the brains of cretins to be small, simply convoluted, and the cortical cells incompletely developed.

Hypothyroidism is due to the atrophy of the thyroid gland shortly before or after birth. Infections or toxic diseases in early

childhood may cause atrophy of the gland but in most cases the cause is unknown. Sporadic or isolated cases are most commonly found in the United States. Many cretins are very greedy even though their metabolic rate is low and unoxidized food accumulates in the body resulting in obesity and general muscular weakness. The subcutaneous fat is irregularly deposited in pads, most commonly over the collarbones or legs.

Since the thyroid gland acts in a very important capacity to regulate nutrition, some children show pronounced improvement, particularly in their physical condition, when subjected to intensive thyroid medication early in the course of the disease. In many cases treatment fails to improve the mental condition but succeeds in removing the physical symptoms. The condition is seldom recognized before the sixth month when the child becomes apathetic, refuses to smile and may not nurse. Except for negligence there apparently is no reason for permitting cretinism to develop in children today, consequently the extreme physical symptoms are less commonly seen. Nevertheless, the prognosis is not promising. Even when the treatment is started early the mental development does not keep pace with the bodily development. Thyroid treatment may have the beneficial effect of raising the I.Q., however, a fairly large percentage remain feeble-minded.

2. *Mongolism*

From one to five per cent of all aments, varying from country to country, are termed mongols from a supposed facial resemblance to the members of the Mongolian race. The distinguishing characteristics are the typical almond shaped eyes of the Oriental, a flattened face, a flattened or depressed bridge to the nose (saddle nose), and a fairly small, rounded, and flattened (front to back) skull. With age the slantish-eye effect tends to disappear, and with it most of the Mongoloid features dis-

appear also. Mongoloid children look astonishingly alike and are most unlike other members of their families.

The lips are fissured transversely, and the protruding tongue has deep, irregular, crosswise furrows. Furrows are also common on the palms of the hands. The hands and feet are broad, stubby, flabby and cold, and there is a wide gap between the first two toes. The hair is sparse, soft and fine. Eye defects are fairly common; a fold of skin usually covers the inner corner of the eye. The ears are malformed and abnormal in size. The skin is smooth and moist, normally fair and covered with fine light hair, though the cheeks are often flushed to a bright red. Knock-knee and flat foot are not uncommon, and joints are extremely lax and mobile. Motor coordinations are delayed and poor; indeed Mongols seldom walk until they are three. Their reflexes are inadequate for the most demanding skills, however, they may be trained in the simplest routines of gardening and house cleaning. Five feet is the usual maximum height at maturity.

Mongoloids appear to have a marked talent for mimicry. They often imitate every gesture of another with the skill and zest of an accomplished actor. This tendency is common in normal children of about two years but disappears shortly thereafter. In Mongoloids it reaches a peak around ten years.

In ability mongolians range from a low degree of idiocy to average morosity, with the majority rating as imbeciles. They learn to obey commands but seldom learn to read. Most mongols have hoarse voices, are very retarded in speech, and some never learn to talk. As a rule fifty words is the highest expectation in vocabulary for an intensively trained mongoloid. They appear to be alert and lively, are generally affectionate, and of a happy temperament. Their docile passivity has marked them as *good* babies.

The general bodily metabolism of mongols is low, they are

subject to disease and a majority die before their first birthday from pneumonia, tuberculosis or some other respiratory infection. While a very few live to the age of twenty their average life span is about fourteen years. Baldness, wrinkling of the skin, hardening of the arteries and other evidences of senility appear in the twenties.

Mongolism is a congenital condition which results in failure of development. This condition can be detected at birth. No cases of normal children developing mongoloid characteristics or growing more mongoloid with age have been reported. A five year old mongoloid looks like a two year old. Until recently it could only be said that mongoloids were a highly consistent and low grade type of mental defective, sharply separable from other types and mysteriously prone to appear anywhere. Many theories as to causation have been advanced including heredity, exhaustion of reproductive powers, the use of contraceptives, parental alcoholism, syphilis, fetal injuries, diminished viability of the ovum, and nutritional, toxic or hormone deficiency affecting the fertilized ovum during the first weeks of embryonic development. Histological studies have shown no specific brain pathology which could account for the maldevelopment of the skull and for the mental deficiency.

Considerable data concerning family background have been compiled. Mongolism appears to strike all kinds of parents—rich or poor, educated or illiterate, dull or brilliant, black or white; and to some extent young or old.¹² They are found in any position in the family. There is a tendency, however, for mongolians to have relatively older mothers and to be among the later children in large families. In studying some 2800 cases of mongolism, Bleyer¹³ found the average age of the mothers at their birth was ten years higher than the average age of American women in general when giving birth to children. More than

half of the mothers of the mongoloids were beyond thirty five, and the older the mother the greater the frequency of mongoloid children. Normally the obstetrician can expect one or two mongoloid births in every 1000. Investigators have found four in 100 for mothers between 40 and 44, and 12 in 100 for those from 45 to 47.¹²

Yet Brousseau's¹⁴ study is typical of several which have shown that the age of the mother is not the sole cause. Mongolian children have been born to mothers under twenty who had given birth to normal children both before and after the birth of the mongol. The age of the father is insignificant. A number of cases have also been reported where one child of a pair of twins was a mongol and the other was perfectly normal. The data on twins¹⁵ tend to strengthen the hereditary theory, particularly since in the cases studied where both children have been mongols the twins have always been of the same sex, while only one child has been a mongol in all cases where the twins have been of unlike sex. Penrose¹⁶ found that in families where one member is a mongol, 1 out of 50 children born to blood relatives is also a mongol, while in the unselected general population mongolism occurs in about 1 out of every 1000 children born.

Most of the recent experimental findings tend to support hereditary and intra-uterine environment as major etiological factors. Tredgold⁹ concluded that mongolism is due to a combination of factors including defective heredity, uterine exhaustion, and some specific nutritional defect during gestation. Some recent studies indicate that toxic and hormone deficiencies, particularly hypopituitarism, may also be determining factors. No adequate medical treatment has been found for mongolism. Glandular therapy has been tried without appreciable results, although in a few cases certain apathetic mongols have become slightly more alert.

3. *Microcephaly*

The distinguishing characteristic of microcephalics is the abnormally small, pointed skull producing a "sugar loaf" appearance. They are popularly known as "pin heads." The skull has a peculiar shape and does not grow to its usual size, since the brain, especially in the cerebral region, fails to develop normally. The forehead recedes sharply, the chin protrudes, and the occipital region is often flattened.

The term "microcephalus" was suggested by Tredgold⁹ when the head is less than seventeen inches in circumference. In some cases, however, this measure is exceeded. Microcephalic brains range in weight from 170 grams to less than 1000 grams, marking them as distinctly smaller than the normal female brain of 1240 grams and the normal male brain of 1375 grams. Although the majority of microcephalics are low grade imbeciles or idiots the mental condition appears to be determined by defects in the structure rather than in the size of the brain since not all are mentally defective.¹⁷ Possessed of fewer and simpler convolutions, the brain is less well developed than the normal brain. Developmental anomalies are common; in some cases certain structures present in normal brains are wholly absent. Nevertheless, the majority show good motor development, and no common sensory or motor defects have been noted. Their movements are characteristically quick and restless. They seldom develop normally in height and many die relatively young. About 0.5 per cent of all aments are microcephalics.

The cause of microcephaly is not definitely known. According to Tredgold⁹ most cases are due to pathological variation of the germ cell. Yet the evidence for a genetic explanation is not conclusive. Penrose¹⁶ found strong evidence of a congenital condition—direct damage to the fetus during pregnancy. He concluded the damage might result from direct injury to the fetus through

maltreatment of the mother or it may be the indirect result of some diseased condition of the mother. There is some evidence to the effect that the condition may result from extensive application of X-rays to the pelvic region during pregnancy.

Too little is known concerning the etiology of microcephaly to provide either preventive measures or medical or other treatment adequate to correct the condition. Segregation through custodial care appears to be the most effective procedure. Microcephalics are found at all social and economic levels and in all countries.

4. *Hydrocephaly*

In sharp contrast to the microcephalics, especially as regards appearance, are the hydrocephalics. Their heads measure fully as much (sometimes more) above normal as do the microcephs below normal. Heads with circumference of 30 inches have been reported. Moreover, the contrast to microcephalics is pronounced not only in size but in shape as well. The foreheads of hydrocephalics are high and projecting and there is a characteristic bulge at the root of the nose and above the ears with the greatest circumference at the level of the temples. Tredgold⁹ describes the skull as globular in shape, with increased uniformity in all directions, the fontanelles tense, the sutures often widely separated, and prominent veins on the thinned scalp are not infrequent. A "top-heavy," balloon shaped appearance, resembling an inverted pyramid, as seen from the front, results from the face diminutive in contrast to the huge cranium. One or more of the following anomalies are usually associated with hydrocephalic mental deficiency; strabismus, nystagmus, cleft palate, harelip, spina bifida (cleft of the spine) and dwarfism. Some common stigmata are shown in (p. 442).

In mentality, hydrocephalics vary from idiocy to dull normal. In a very limited number of cases they may approach normal

mentality. Few of them ever learn to talk. The small number who do are ordinarily defective in speech. When the disorder is progressive, as is usually the case, mental impairment also continues. Sight and hearing are often defective, and epileptic and paralytic seizures are frequent. The lower extremities are more often and usually more severely affected than the arms. Many of these children are unable to walk or play due to weak muscles, poor coordination, and the enormous size of the head. Many are confined to bed with wasted bodies and limbs. Most hydrocephalics are quiet, cheerful, friendly, even-tempered, and affectionate.

There are two types of hydrocephaly: the internal, and the external. In internal hydrocephaly, which is most frequent, the cerebrospinal fluid accumulates within the ventricles of the brain as a result of malformations of structure or tumor growth which obstruct the circulation of the fluid. In external hydrocephaly the fluid is located between the hemispheres of the brain and the skull. Infectious diseases, such as chronic meningitis and congenital syphilis, causing an inflammation of the meninges, result in the formation of foreign tissues which obstructs the flow of cerebrospinal fluid to and from the cerebral subarachnoid space. The condition may be present during the intrauterine period, but the symptoms often do not become apparent until some time after birth. The infant may die in delivery when the condition is fully developed at birth. The younger the age of onset the less favorable the prognosis, since the pressure of the excessive amounts of fluid, averaging a quart or more, gradually destroys the brain cells. In pronounced cases Sherman¹⁸ found both the convolutions and the sulci of the brain completely imperceptible and the brain substance itself greatly reduced.

No successful method for the arrest or cure of hydrocephaly has been found. Surgery to drain off the cerebrospinal fluid, while bringing temporary relief, has proved ineffective. The

drained cranium refills in a day or two. Most cases die in infancy. Even when the condition is arrested the victims die relatively young, very few attain adulthood. They frequently live a few years longer in institutions where they are carefully supervised. Custodial care is advisable.

5. *Miscellaneous Types*

In addition to the four major clinical varieties described above mental deficiency with sundry physical anomalies may result directly, or indirectly, from various miscellaneous causes most of which may be classed as secondary or exogenous. The role of syphilis in producing feeble-mindedness has been over emphasized. Nevertheless, children born to parents, one or both of whom are syphilitic, may be infected at the time of conception, through the placental circulation while still in utero, or during the birth process. Such early infection may result in brain lesions with resulting mental deficiency. Abortions and still births occur frequently in such cases. Of those born alive, some may be small but appear normal at birth, and although they continue to remain small no deficiency is suspected until about one year when they develop epileptic seizures, become paralyzed and mental retardation is evident. A large number are imbeciles or idiots, and are further handicapped by serious visual and/or auditory disturbances, convulsions, and paralysis, especially of the limbs. Since mental deficiency due to syphilis is attributed primarily to infection of the fetus by the mother, prevention consists chiefly in treatment before or during pregnancy.

Doll¹⁹ has presented evidence indicating that mental impairment may be caused by difficult, prolonged, or instrumental delivery resulting in intracranial lesions and hemorrhages occurring during birth. He attributes from five to ten per cent of all cases of amentia to birth injuries. His findings show that ten per cent of all children suffer damage at birth sufficient to produce blood

in the cerebro-spinal fluid. The injury may affect any area of the brain resulting in either mental or motor impairment, or both. Brain injury during the early months of life may prove equally serious. Although possible, feeble-mindedness is rarely due to head injuries in early infancy. Many individuals with mental disturbance due to birth injury benefit more from wise and early educational training than do some other types of aments. Improved obstetrical methods and care, endocrine treatment, improved feeding, incubators, and the use of vitamin K to stop hemorrhages, have resulted in some improvement.

There is also a marked tendency for intelligence to deteriorate slowly and progressively following an attack of encephalitis lethargica, or sleeping sickness as it is popularly known. This deterioration appears to indicate progressive damage to the brain.²⁰ The mental deterioration may be very severe and is frequently widespread affecting all aspects of personality. Cheerful, obedient children, may become irritable, restless, defiant and disorderly.²¹ Emotional outbursts occur frequently. Although the disease is relatively rare, some mental disturbance appears to result in 70 per cent of all the cases. In contrast to previous investigators, Bond and Appel²² found that planned education in a controlled environment may be beneficial to some post-encephalitic children.

In a relatively small number of cases mental deficiency may be attributed to cerebral lesions or inflammation of the brain and its meninges resulting from acute infectious diseases, such as diphtheria, measles, scarlet fever, whooping cough, pneumonia, and influenza occurring in early infancy; acute inflammatory diseases; brain tumors; prenatal and postnatal undernourishment, especially lack of vitamins; and, perhaps most frequently, convulsions, severe epileptic seizures in particular. Analysis of intelligence test results²³ have shown consistently that the average mental level of institutionalized epileptics is below normal. In-

stitutionalized patients include cases which may have gross cerebral damage. But Lennox²⁴ also found almost one-half of 2000 patients showing some mental loss after twenty-five years of clinical observation.

G. Education and Treatment

The education and treatment of mental defectives depend upon many factors other than mere intelligence. Intelligence as measured by tests is no longer assumed to be an innate or fixed characteristic of the individual. Many recent experiments have shown that test performance is dependent upon training and environment as well as upon innate ability. Woodrow²⁵ found that the feeble-minded child improves with practice in simple mental operations just as rapidly as the normal child of the same mental age. This finding has important implications for training. The adult moron too can learn simple tasks as easily as normal children of nine but he cannot perform complex tasks. Although his rigidity increases with age the mental defective never develops a highly differentiated, rigid mental structure because of his poor potentialities for development. He is definitely limited and cannot be expected to go beyond a certain point. The main problem is to train him to take a place in society that is within the limit of his possibilities. His personal, social and vocational training should be so organized that he will be able to adjust himself with a minimum of outside help. Except for the few who are very low in intelligence there is not a direct relationship between personal, social, and vocational competence.

Personality disorders are very common among mental defectives due primarily to their difficulty in making wholesome social adjustments. They tend to be isolated by other children as a result of their inability to compete with them and to attend to their own needs without assistance and supervision. Placing them in special schools or in special rooms frequently accentuates

their difficulties. They are set apart and made more conscious of their deficiencies. A high grade moron frequently develops conflicts concerning his competence since he is aware of his inferiority. Other children, and at times some adults, take advantage of him. As a result it may be necessary to institutionalize him because of his personality aberration rather than his low intelligence.

When all types of mental defectives are included they constitute a group far too large for all to be institutionalized. The idiot and low imbecile group require custodial care, they are essentially institutional problems. Many of the secondary or exogenous cases fall in this group. Though they are more striking than the endogenous cases who seldom manifest distinguishing physical characteristics they constitute a less serious problem for society. It is the morons and high grade imbeciles with no other marked handicaps that present a very real challenge. They cannot compete on equal terms with normal persons but there is a place for them in our society. The higher type of mental defective requires a different type of education than the normal person. He cannot be taught the same things nor in the same way, but he can be taught some things which will assist him in making better economic and social adjustments. It is usually advisable to postpone school matriculation one or more years. Special schools or special classes with the grading of all instructional materials according to the abilities of the pupils are essential. Systematic occupational training should be made available to all higher grade defectives, and at an earlier age than is common for the average child. If carefully supervised and directed about 70 per cent of those with I.Q.'s above 60 can be trained to take care of themselves economically and to lead useful lives. With training and supervision adult imbeciles can do many simple routine phases of housework, farming, gardening and simple industrial and mechanical operations, while adult morons can be

trained to carry on somewhat more complex routine tasks in these fields. They can also be trained to assist with many types of skilled or semi-skilled labor, such as carpentry, painting, paper hanging and shoe repairing. Consequently, it is unwise to commit them to state schools until an earnest effort has been made to train them to become wholly, or at least partially, self supporting.

1. *Sterilization*

A suggestion frequently made which is considered one of the most hopeful solutions for decreasing the incidence of feeble-mindedness is the sterilization of all defectives to prevent child-bearing. Although present evidence seems to indicate that intelligence is predominantly inherited, the evidence that most mental deficiency is due to heredity is not conclusive.

Many states have enacted eugenic sterilization laws, but the groups subject to sterilization vary widely, and in some cases strong opposition has prevented enforcing the laws. Jennings²⁶ concluded that about 11 per cent of the feeble-minded in any one generation result from the mating of mentally defective persons. Consequently less than one mental defective out of every nine would be eliminated by sterilization.

A program of eugenics might eliminate mental deficiency if feeble-mindedness is transmitted through a single recessive gene. Jervis²⁷ found some evidence to support this view. Most authorities in the field, however, consider intelligence dependent upon many factors. It does not follow the laws of inheritance of unit characteristics, but rather it seems to follow a highly complex pattern. Scientific knowledge of hereditary factors is inadequate to justify an extensive program of eugenic sterilization at present.

In light of these considerations the most effective treatment for mental defectives then seems to resolve itself into educating them to make the most of the abilities they possess. With a reasonably

favorable environment the outlook is more optimistic than was once thought. Although the percentage of indigent and unemployed is much higher for the feeble-minded than for the general population, studies indicate that a majority of morons are self supporting, and are not a burden to society.

III. Mental Disorganization and Deterioration

Deviations in intelligence vary in both degree and kind in almost every form of mental disease, in the neuroses as well as in the psychoses. In contrast to amentia, which is characterized by impairment in the capacity for intellectual development resulting in mental deficiency, there is either a temporary, or a permanent loss of intellectual efficiency in most forms of mental disease. There is usually no deterioration of intellect in the neuroses, but there may be periods when some mental functions are temporarily beyond voluntary control. The interference with intellectual efficiency is a result of disorganization, temporary dissociation, inability to remember, concentrate, or think clearly. The mental disruption is more profound in the psychoses, here there may be a progressive loss of intellectual efficiency with gross mental deterioration during which time the patient has little or no insight into his condition. The term *dementia* is used to denote such loss of mental ability or such mental deterioration.

A variety of techniques have been developed to determine the amount of intellectual impairment. One of the most direct methods of evaluation necessitates repeated measures with the same or comparable tests of the same subject over a period of time to determine the decline in test scores. Accurate estimates of the subject's intelligence prior to his illness are rarely available. Consequently, more indirect measures in terms of particular incidents in the educational, vocational and social history of the subject; differences in the subject's performance on various sub-

tests in intelligence scales, disorders of attention, memory, association, thought and awareness, and ability to deal with abstract relationships are used as indices of deterioration.

A. Mental Disorganization

1. *The Neuroses*

The intellectual disturbances in the neuroses or the psychoneuroses, as they are often called, are less deviant from the normal than in the psychoses. The neurotic exhibits more insight into his condition and is in better contact with reality. His thought processes are relatively coherent and logical and he is capable of self-management, but his mental condition may decrease his work efficiency. As a rule his symptoms respond favorably to suggestion, reeducation, or other psychological techniques. The prognosis is usually more favorable than for most forms of psychosis since the disorganization is likely to be limited, and he seldom suffers permanent intellectual impairment.

Symptoms of mental disorganization in hysteria, a form of neurosis for which no organic or physiological cause has been demonstrated, are loss of memory (amnesia) and various trance states in which normal consciousness is disturbed. There is inability to remember events during some period of time, in which one would normally remember. In some cases there is disintegration of the main personality resulting in dissociation, that is, a splitting off of groups of ideas. The dissociated fragment may be integrated and lead a relatively independent existence, as is the case in somnambulism (sleep walking), or in a fugue, an episode of acting as a different person and migrating to a new environment.

Loss of interest and inability to concentrate and think clearly are disturbed mental symptoms found in anxiety states, in neurasthenia and in the compulsion neurosis. Wechsler⁴ found the scores on the verbal sub-test of the Wechsler-Bellevue Scale gen-

erally higher for neurotics than the scores on the performance items, although he found many exceptions, especially in hysterics and obsessives. The tests which require immediate effort, such as the Picture Arrangement, Object Assembly, Digit-Symbol and Digit Span offered particular difficulty. Their performance was a challenge which often resulted in hesitation, blocking, balking at various items, or an excess of trial and error. Tendler²⁸ suggests that the inferiority of neurotic patients on the Digit Symbol Test is due to some sort of associative inflexibility in the subject and a tendency toward mental confusion. They have difficulty in concentrating and applying themselves for any length of time and their emotional reactivity interferes with any task requiring persistent effort. This represents a lessened mental efficiency rather than an impairment of intellectual ability.

Highly varying performance on the Digit Span Test for neurotics was found by Wechsler. Some passed the more difficult items and failed the easier ones. They frequently repeated as many or more digits backward as they did forward. The neurotics generally overestimated their own intellectual ability, and patients characterized by anxiety and depression required continued reassurance.

In analyzing the Rorschach Test results of neurotic patients Beck²⁹ cites a case of marked depression in which the depressed mood disorganized the intellectual life so severely that there was almost complete inability to think. The number of responses was so small as to indicate the feeble-minded level and the reaction time was abnormally slow. Klopfer and Kelley³⁰ also emphasize an abnormally low number of responses, perplexity, and impotence as indications of a profound neurotic disturbance.

2. *Schizophrenia*

Among the psychoses disorganization of intellectual functions is pronounced in schizophrenia. In some cases there seems to

be very little, if any, permanent deterioration. Considerable research has been carried on with schizophrenic patients over a period of several years which has resulted in a vast amount of data, some of which are conflicting.

The first evidence of mental disturbance ordinarily noticed in schizophrenic patients following the onset of the illness is loss in the rapidity of mental functioning. As the condition develops association and conceptual thinking become disturbed and memory for recent events is impaired. Wechsler found relatively low performance for all schizophrenics on the Object Assembly and on the Digit-Span Tests, and poor scores for certain types of schizophrenics on the Comprehension, Arithmetic, Similarities, Picture Completion and Picture Arrangement Tests. Impairment of intellectual efficiency was most evident on tests calling for immediate and directed effort, and in inability to deal with concrete and specific situations.

The vocabulary test in the Wechsler Scale is very helpful in many instances in revealing the character and quality of the subject's thought processes. The formal aspects of the schizophrenic's language disturbance may be diagnostic. This is particularly true of certain subtle aberrations pertaining to bizarreness of ideational content and peculiarities of expression. Wechsler cites the following definitions which are typical of schizophrenic patients: *Plural*—"a way of thinking in grammar." *Bacon*—"a part of a pig associated with breakfast." Other vocabulary characteristics of schizophrenics are marked perseveration, redundancy of definition, and incoherence of content. The Comprehension Test may also suggest the presence of schizophrenic trends as revealed by perverse and bizarre responses.

Olech³¹ found no statistically significant differences between the I.Q.'s of schizophrenic subjects on the Performance and Verbal Scales of the Wechsler-Bellevue Scale. However, highly significant differences were found between younger schizophrenics

and normals on test scores for the Digit Symbol, Comprehension, Similarities, and Picture Completion tests. The differences between older schizophrenics and normals on the above four tests plus the Picture Arrangement test were likewise found to be statistically significant. The Digit Symbol and Similarities tests were found to be most difficult for both groups. She also found the variability in test performance considerably greater for the schizophrenics in her study than for Wechsler's normal groups. The performance of schizophrenics is often unpredictable. Some patients may do very well on certain tests which are commonly failed by the majority.

The necessity of noting the differences in diagnoses and diagnostic criteria used in different institutions in comparing the results of studies using schizophrenic patients is stressed by Garfield.³² He found the degree of illness of the particular patients used an important factor in explaining differences. More variability and intellectual impairment were found where schizophrenic patients of long standing were used. The precise time at which the patient is tested is also of some significance since schizophrenics tend to be variable in their behavior. Another subjective factor which may influence test results is the degree of motivation and rapport secured with patients. Factors such as these contribute to the variations in findings from different institutions and help to account for discrepancies among the various studies. It is safe to conclude that the use of intelligence test performance to detect mental disturbance is definitely limited at the present time. There are no scientifically demonstrated scatter patterns for psychometric tests which can be applied generally in institutions.

B. Mental Deterioration

While the loss of intellectual efficiency in most neuroses and some forms of schizophrenia accompanying mental disorganiza-

tion is not necessarily permanent, the mental impairment characteristic of senility, organic psychoses, and other brain damage is usually irreversible.

1. *Normal Deterioration*

A gradual decline in intellectual efficiency is normal with increase in age independent of any specific mental disease. The decrease in speed, accuracy, and efficiency occurring after maturity normally takes place so gradually that few people realize there are marked changes in themselves or in those about them before the age of fifty. They tend to confuse intellectual endowment with practical ability which may increase with experience and compensate for the decline in native ability. The condition known as senility results when mental impairment is pronounced.

The decline in brain weight from 15 to 65 years of age³³ parallels closely the age curve for intellectual ability obtained by Wechsler in standardizing his scale. The mean brain weight reaches a maximum during the age range 20 to 25 years, and declines at a fairly constant rate after that time. These changes in weight undoubtedly affect the functioning of the brain as evidenced by the Digit Span, Arithmetic, Digit Symbol, Block Design, Similarities and Picture Arrangement Tests in the Wechsler Scale which decline quite rapidly with age. The decrease in scores is most significant for the performance tests and the test for Memory Span for Digits. Motor skills reach their highest efficiency before the age of 30 according to extensive studies by Miles,³⁴ and show a slow but constant decrease thereafter.

Reasoning quickly and intelligently about new problems becomes more difficult with the slowing down of mental life, while ability to exercise judgment dependent on well-established habits may improve. The Information, Comprehension, and Vocabulary tests of the Wechsler Scale hold up very well with age. These

changes in mental functioning may well account for persons becoming more conservative, frugal even miserly, and opinionated with advancing years. These facts are more significant with the increasing median age of the American population and the declining birth rate. From 1850 to 1940 the percentage of the population over 65 years of age increased from 2.6 to 6.9 per cent.³⁵

2. *The Organic Psychoses*

Senile dementia and cerebral arteriosclerosis while presenting different anatomic processes show many clinical resemblances. Both are advanced stages of mental deterioration which are fairly common after the age of 60 or 65. The onset, particularly of the latter, is usually more sudden than in normal deterioration. Both are characterized by extreme confusion and disorientation. Not infrequently there is an exaggeration of the conservative and egocentric tendencies noted in the aged. Impairment of memory, loss of attention and interest, and errors of judgment are symptomatic of intellectual failure.

Little is known concerning the extent or kind of mental deterioration which may take place in involutional melancholia partly because of the difficulty in securing the cooperation of patients necessary for test performance. Evidence of brain damage has rarely been reported.

The degree of mental deterioration found in general paresis ranks close to that found in senile dementia. Intellectual weakness and deterioration are the characteristic qualities of paretics. As a rule the first abnormality noted is loss of judgment which continues to increase in severity. Disorders of memory, errors of time relations and continuous loss of ideas are pronounced. Although retaining the fundamental number combinations, great difficulty is encountered in using them for even the simplest calculations. Paretics are readily distracted, their thinking is

confused and aimless with imagination filling in the missing links. Errors in both writing and speech are manifested. Inaccuracies, omissions and transposition of syllables are common.³⁶

Some degree of mental disorganization or deterioration is commonly exhibited in most disorders resulting from the excessive use of alcoholic beverages. The mental disturbances may be intermittent and temporary in the beginning, though the continued use of large amounts results in irreparable brain damage and intellectual impairment. The results of standardized tests indicate that major psychological changes follow pronounced neural deterioration. The usual psychological tests, however, have limited value since addicts are usually evasive, uncooperative, and unreliable. The nature of the mental disturbance varies with the clinical pattern. Some of the distinguishing symptoms noted are:

Acute Alcoholic Intoxication—impaired judgment, tendency toward flight of ideas, dulled perception;

Acute Alcoholic Hallucinosis—delusions of persecution, auditory hallucinations, acute episodes persisting a few weeks;

Chronic Alcoholic Deterioration—speech defects, dearth of ideas, forgetful, distorted judgment, poor comprehension;

Delerium Tremens—incoherent, distractable, disoriented, confused, amnesiac, severe illusions and hallucinations;

Korsakoff's Psychosis—agitated, disoriented as to time and place, visual and auditory illusions and hallucinations, tendency to fabricate, anterograde amnesia.

The mental disturbances resulting from the organic psychoses listed above account for a large percentage of first admissions to mental hospitals. Other forms of brain damage which may cause intellectual impairment in a more limited number of cases are cerebral embolism; cerebral hemorrhage; brain tumors; trauma, especially war injuries; and infectious diseases producing lesions in the central nervous system.³⁷ The nature of

the mental changes varies with the extent and location of the damage. In general they are almost certain to be revealed by measuring speed of response, learning, and the ability to perceive new configurations, particularly spatial ones.

3. *Psychopathic Personalities*

In addition to the neurotics, the psychotics, and the mentally deficient are a miscellaneous group of abnormal individuals who are classed as psychopaths or psychopathic personalities. There is no syndrome which differentiates this group from the others. It is not characterized by mental deficiency, disorganization or deterioration as described in the preceding sections, and yet a majority manifest symptoms of intellectual disturbance.

While there is marked lack of agreement as to the nature of psychopathic personalities most all descriptions place particular emphasis on inadequate social intelligence. Most individuals so classified manifest phenomenally poor judgment in matters involving the emotions, seeming frequently to act upon impulse. They are unable to exercise foresight to control their immediate desires. In certain special fields they are unable to profit by experience and to understand what society expects of them. And yet on the basis of intelligence tests they usually rate average or superior. With few exceptions the adolescent psychopath earns a high performance score on the Wechsler Scale as compared with his verbal test score. Many psychopaths make very good scores on the Picture Arrangement test which has been interpreted as measuring social intelligence. They tend to earn low scores on the Information, Similarities and Arithmetical Reasoning tests. Verbally they often show evidence of good judgment in planning for past errors but it has little influence on their behavior. Their weakness appears to be a highly specialized mental deficiency or deterioration.

IV. Mental Superiority

Abnormalities of intellect extend in two directions, toward the more and toward the less. Whereas the subnormal comprise the lower end of a continuous frequency distribution of intelligence, the upper end of the curve, at the right of the average, is represented by the supernormal. In the sense that they are equally distant from the normal the superior deviates are as abnormal as are the inferior. Since the frequency curve "has usually been found to be fairly" symmetrical in a random sampling of the population the percentage of supernormals is approximately equal to that of the subnormals.

The existence of the more extreme superior deviates was recognized by the ancient Greek writers but like the feeble-minded they were believed to constitute a distinct group set apart from the rest of mankind. The concept of a continuous curve of increasing levels of superiority, corresponding roughly to the inferior levels, developed with the extensive use of psychometric tests. Three levels of superior ability have been variously classified as the superior or rapid learning with a minimum I.Q. at least plus 2 P.E. deviations above the mean, the very superior or mentally gifted with I.Q.'s of plus 3 or more P.E., and the genius or near genius who cannot be classified on the basis of intelligence test scores alone. Many have I.Q.'s from plus 5 P.E. to plus 10 P.E. or more above the mean.

A. Degrees of Superiority

1. *Superior Mentality*

The rapid learner was not recognized as exceptional until the past few decades primarily because he rarely presented problems. In fact, until modern methods of education were introduced they were considered as average since pupils of average or lesser ability seldom survived school failure. They were given little attention and allowed to make their own adjustments. Many su-

perior students did not have an opportunity to enjoy high school and college educations. Even at the present time optimal educational opportunities for the mentally superior are far from being achieved.

In terms of intelligence rapid learners range in I.Q. from about 120 to 130 or 140 although no definite limit can be set. Their intellectual efficiency, in sharp contrast to the mentally deficient, the mentally disorganized, and the mentally deteriorated, is characterized by ease of assimilation, sustained attention, quick reaction time, rapid reading habits, keen language ability, intellectual curiosity and initiative, versatility and vitality of interest, logical and accurate memory, and ability to generalize. They are able to coordinate several functions, apply their knowledge, suspend judgment until necessary data are at hand, and are sensitive to the intellectual and esthetic elements in a situation.³⁸ The more difficult items in the Information and Similarities tests and Vocabulary seem to be the most reliable tests in the Wechsler Scale for differentiating the superior. As a group they enjoy better health than subnormals, and their personality adjustments are better. A majority come from homes which are above average and they attend school more regularly. They often develop poor habits of school work because of inadequate competition. A major problem is developing and utilizing their resources to the fullest extent possible.

2. *The Mentally Gifted*

The highest two percent of the general population are designated as mentally gifted or very superior. According to most classifications the lowest limit of the I.Q. range is about 130 to 140. Wechsler states that it is impossible to measure general intelligence beyond a certain level. He considers I.Q.'s above 130 as representative of special aptitude in intellectual ability rather than a superior level of intelligence. There are qualities

other than verbal or abstract intelligence which are to be considered in the mentally gifted.

In general increasing levels of mental superiority are differentiated by a desire to know, originality, will and perseverance, self-confidence, prudence and forethought, desire to excel, sense of humor and conscientiousness.³⁹ Hollingworth and Cobb⁴⁰ found no measurable differences in educability for two highly selected groups, one clustering around 146 I.Q. and the other around 165 I.Q., in simple learning processes. The differences became clearly perceptible, however, as the processes to be mastered became more complex, containing more elements which must be related to each other spontaneously, such as reading for the comprehension of difficult material. The study demonstrates that the mentally gifted are more educable than the superior, and that the difference is revealed most clearly as the mental processes involved become more and more complex.

Some facts established by a twenty-five year follow-up of mentally gifted cases by Terman and Oden⁴¹ indicate:

That their mortality rate to age thirty-five is lower than for the generality, some of which may be credited to superior home environment.

That versatility rather than one-sidedness is the rule.

That to near midlife they show a normal or below-normal incidence of serious personality maladjustment, insanity, delinquency, alcoholism, and homosexuality.

That, as a rule, those testing above 170 I.Q. as children were more often accelerated in school, got better grades, and received more schooling than lower-testing members of the group; that they are not appreciably more prone to serious maladjustment; and that vocationally they are more successful.

That the intellectual status of the group is far above the average level of ability of graduates from superior colleges and universities.

That in vocational achievement the gifted group rates well above the average of college graduates, and as compared with the general population is represented in the higher professions by eight or nine times its proportionate share.

That their vocational success is greatly influenced by motivational factors and personality adjustment.

That the incidence of marriage in the group to about age thirty-five is above that for the generality of college graduates of comparable age in the United States, and about equal to that in the general population.

That marital adjustment of the gifted, as measured by the marital happiness test, is equal or superior to that found in groups less highly selected for intelligence, and that the divorce rate is no higher than that of the generality of comparable age.

That the sexual adjustment of these subjects in marriage is in all respects as normal as that found in less gifted and less well educated groups of married couples.

That the test of marital aptitude predicts later marital success or failure in this group a little better than the test of marital happiness, much better than the index of sexual adjustment, and almost as well as scholastic aptitude tests predict success or failure in college.

That offspring of gifted subjects show almost exactly the same degree of filial regression as is predicted by Galton's law.

That the fertility rate of the group to about age thirty-five is probably below that necessary for the continuation of the stock from which the subjects come, and that this stock is greatly superior to the generality.

Even more than the superior the mentally gifted present a very real challenge to society. Although better educational facilities are provided in some schools today there is still a great loss of intellectual resources and efficiency in the failure to develop

effectively and fully the rich potentialities of the mentally gifted.

3. *Genius*

As previously noted the relatively few who achieve the eminence acclaimed as genius cannot be defined on the basis of their rarity or uniqueness on intelligence test achievement alone. What a man does as well as the expertness with which he does it is important. He must manifest the kind of exceptional ability demanded by his culture. As defined by Galton⁴² a genius is a man "who (because of his eminent work) achieved the position of one in each million." They are those "whom the whole intelligent part of the nation mourn when they die, who deserve a public funeral, and whom future ages rank as historical characters." Distinction based on the permanence of the contribution which an individual makes to his culture is noteworthy. The effects of his contributions to civilization persist for generations. The basis for eminent achievement classed as genius thus appears to combine marked intellectual superiority with a special talent of high degree, but specific social criteria and a cultural sense of values are also determining factors.⁴³

Careful biographical studies of men who have achieved eminence, and controlled developmental studies over a period of many years of children showing unusual promise contradict the early highly erroneous conceptions and some of the more recent traditional beliefs concerning the genius. Contrary to early theories he is not superhuman nor is he gifted with divine inspiration. His abnormality cannot be characterized as a neurosis, a psychosis or a form of degeneracy. He is not inferior to the average physically, socially or morally, and he is not lacking in general ability.

Among the major attributes of the genius are his profound intellect, creative ability, zeal and sustained power of working. He sees farther and probes deeper than other people, and he has

vision and energy to develop his specific talents unless he is hopelessly thwarted.⁴⁴ His family background is decidedly superior intellectually and somewhat superior physically. The mean I.Q. of his siblings is superior but not as high as his own. Subject failures for the genius are very rare. School achievement is usually exceptionally high in all subjects. He shows no ill effects of more rapid promotion than the average. A large majority earn one or more university degrees, and are elected to Phi Beta Kappa and/or Sigma Xi. From two-thirds to three-fourths enter professional pursuits and earn incomes decidedly above the average of the general population.⁴¹ And yet with all their rich potentialities perhaps no group of abnormals in the American population has been less well understood and more hopelessly neglected than the mentally superior. Unfortunately the misunderstanding and neglect have been more flagrant the greater their deviation above the mean.

B. Education and Treatment

The mentally superior require practically as much special attention and care as do the subnormals. Many bright individuals have been handicapped by unwise training. Systematic education began among the supernormal and for centuries was largely limited to them. Some with highly superior endowments were privately educated and made remarkable progress. But as public education spread to the masses the schools became less appreciative of the extremely gifted and the educational provisions became less adequate.

In addition to the private and experimental schools, many of which are limited to the very superior, some provision for the education of the more fortunate deviates has been made in the public schools during the past half century. Arrangements for rapid acceleration, sectioning on the basis of ability, enriched curricula, and major work programs have been provided.

The education of the gifted should stress initiative and originality. To enable them to contribute to society in proportion to their intellectual endowments requires not only a broad background of knowledge; but wholesome social, emotional and personality adjustments; and experience in activities of a higher order, involving training for understanding and leadership in international situations and a world order as well. The contributions of potential genius are priceless. Utilizing their rare endowments wisely presents a stupendous problem which increases in complexity with increasing levels of superiority.



Fig. 1

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OF
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By

PETER D. FLEMING, M.D., Psychiatrist
Winter Veteran's Administration Hospital, Topeka, Kan.

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BY J. D. MERRILL, M.D., F.R.C.P.

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Chapter XII

CERTAIN FORMS OF NEUROSES

By PETER D. FLEMING, M.D., Psychiatrist*

Winter Veteran's Administration Hospital, Topeka, Kan.

I. Introduction

The incidence of psychoneurosis is difficult to detect and appraise. Many persons who are suffering from a psychoneurosis never come to the attention of those who keep statistics. Neurotic persons may manage to get some help from friends, relatives, teachers, pastors and so forth. Relatively few find their way to psychiatrists, mental hygiene clinics or those psychologists and social workers who specialize in treating this condition. Unfortunately, certain neurotic persons are never recognized as such. Many delinquents, family relations courts' clients, chronic relief cases, habitual criminals and other chronic failures are psychoneurotic people who are being treated symptomatically and thus not adequately.

Recent statements from certain general practitioners with a psychological bent, indicate that as much as half of all of the cases they see are really neurotic persons, whose various pains and discomforts are not due to organic pathology. We have every reason to suspect, therefore, that the prevalence of neurosis is high. The person who has not had some neurotic difficulty at one

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time or another is as rare as the person who has never had a head cold.

In spite of the great incidence of psychoneurosis, it has not been possible to propose a simple definition. As a matter of fact, the difference in the definitions of various investigators has been an outgrowth of the realization of how widespread the disorder is. The more we have learned about people and their emotional life, the more complicated the concept has become. The young science of abnormal psychology has been frequently criticized for the indefiniteness of its terminology.

Although mental illness is properly considered to be in the realm of medicine, it differs from all other illnesses in that it is intimately tied to the culture. A cold is a cold in New York and in New Guinea. However, the wearing of long hair today by men would indicate a mental aberration in New York, but not in New Guinea. On the other hand, it would not have been considered unusual two hundred years ago.

The new born child is propelled into the world with certain hereditary and constitutional propensities and limitations. With these reservations, the child is free to develop certain physical and psychological characteristics. With adequate diet, warmth and protection from the elements, and barring accidents and crippling illnesses, the individual will develop to the upper limits of his physical endowment. With an adequate amount of love, interest and guidance, barring severe social and emotional trauma, the individual will develop to the upper limits of his psychological endowment. Just as the chance affliction with infantile paralysis may effect the over-all physical height, so certain situational and emotional experiences produce psychological effects.* Differences in personality are accounted for by the dif-

* The division into mental and physical characteristics is certainly open to question. The most recent thinking no longer separates the mental (psyche) and physical (soma) but combines them as mental-physical (psychosomatic). It will have occurred to the reader that the mental aspects of so severe a disease as infantile paralysis, in other words the feelings present in the person who has been so afflicted, are as important as the physical crippling.

ferences in past emotional experiences. Exacting studies of the past life of people will allow us to understand why they have the kind of personality they have.

It is very important to emphasize at this time that the phrase, "emotional experience," does not stand alone but is intimately tied to the physical characteristics of the person. The death of the mother can of course be very traumatic for a normal ten-year old, but the death of the mother can be catastrophic for the ten-year old hopelessly bedridden. When the emotional and situational experiences of the past interfere with a person achieving a reasonably happy, productive and efficient life, there is mental illness. If such a person can distinguish what is real from what is imaginary and if there is no intellectual deficiency he is considered psychoneurotic.

The past emotional traumata appear to operate as if they were still extant. Today's occurrences are reacted to as if it were still yesterday. Neurotic people, in a sense, are living in the past. Thoughts, feelings, and behavior, more characteristic of childhood and more appropriate to that time, dominate. Persons reacting in this way, the neurotics, are not aware of this and even if they are, they can do nothing about it without help.

Some observers stress another feature which they feel is characteristic of psychoneurosis; the absence of organic pathology associated with the presenting discomforts of the person. This is only partially true, however. The presence of a concurrent physical disease of course does not eliminate the possibility of a co-existing psychoneurosis. This is the case when there is severe disability in response to minimal organic pathology or when severe and chronic emotional difficulties produce organic damage. For further information on the latter, see chapter on "Psychosomatic Medicine."

Below is a list of a few of the things that may become of emotional traumatic moment to the developing individual, how-

ever, also difficult to evaluate exactly:

1. Being an unwanted child in any sense and including the timing of the birth and the sex of the infant.

2. Any disturbance of the usual parental constellation, consisting of a reasonably masculine father and a reasonably feminine mother who live with the child most of the time. Disturbances in this area can refer to death or separation of the parents, the enforced living outside the home by the child for any cause, occupations of the parents which keep them away from the home for long periods of time, characterial peculiarities of the parents, etc.

3. Disturbances related to the absence of siblings or the presence of too many siblings with either too little or too great attention to the individual in question. Too severe competition with siblings.

4. Physical handicaps, including constitutional weaknesses or deformities of physique including marked ugliness, accidents and crippling illnesses. Prolonged physical illness with alteration of the milieu.

5. Insecurities in the community for any reason including war, depressions, prejudices, etc.

The time of occurrence of any particular experience is very important. Parental separations, for example, are likely to be less upsetting to a ten-year old than a five-year old. A six months illness coupled with family financial insecurity would doubtless be less disturbing if they occurred successively.

Although it is wise to be aware of the various things that may constitute traumata for the developing personality, one must bear in mind that these will always be weighed differently by the different people experiencing them, dependent in turn on still earlier experiences. It follows then that it is the very earliest years of life which are so important in determining the final personality and whether it is neurotic or not. More will be said about this later.

II. Symptoms

A. Necessity of Understanding Causes

When dealing with essentially non-psychiatric illnesses, the term symptoms refers to the complaints, the pains and the discomfort suffered by the ill person. Symptoms make a person seek help, and they indicate that something is wrong. Many symptoms, however, in both general medicine and in mental illness are really spontaneous efforts of the diseased person to heal himself. The pain of a fracture not only indicates the presence of the broken bone, but also causes a limitation of movement of the injured part. It thereby prevents further damage by sharp bone fragments and facilitates healing. No matter how excruciating the pain may be, it still has a meaning in the economy of the individual.

This same principle applies to the psychoneurotic entities. No matter how discomfoting the symptom may be, it also evidences an attempt at spontaneous recovery. It is usually difficult for the initiate in the study of abnormal people to accept this.

The individual with a fracture usually seeks medical aid for his pain, and the physician relieves the pain by treating the fracture. The same is true of the neurotic. He comes for help because of pain, but the cause must be treated.

It is worthwhile to carry this analogy one step further. In the case of fractures, it is almost impossible to relieve the pain due to the broken bone, unless the fracture itself is treated, as for example by splinting the affected part. This is true too of neurotic symptoms. The discomforts of neurotics are rather resistant to help, unless the cause itself is treated.

Trying to cheer up neurotically depressed people, does not work. Understanding the cause of their depression does. Symptomatic treatment of the city-dweller who fears snakes would be to forbid his going to the zoo. The underlying difficulty causing

this symptom remains untouched, however, and soon the fear of snakes spreads to other things he cannot avoid and still live a normal life.

B. Symptoms Are Compromises

In the process of living, we are repeatedly confronted with conflicts which require some sort of solution. Solutions which are accompanied by discomfort, we speak of as symptoms. A careful study of the formation of symptoms reveals that the solution is really a compromise which partially satisfies the two opposing sides of the conflict.

Such conflicts are not limited to our conscious experiences, but may occur in the deeper recesses of the mind. The following brief case illustration shows how symptoms are compromises in an attempt to partially satisfy both sides of a conflict: A married woman was brought to the psychiatrist by her distraught husband. She was suffering severely from incapacitating heart attacks consisting of pain over the heart region, fears that her heart would stop beating and that she would die and a resultant inability to care for her family and home. Very careful physical examination revealed no indication of a heart disorder. This woman however suffered great anxiety and was sufficiently uncomfortable to have consulted many physicians.

Painstaking study of the emotional life of this woman revealed that although she loved her husband dearly, she was such a dependent person that her husband fell far short of satisfying her great needs to be treated as a helpless young girl. Though he was reasonably kind, considerate, and affectionate, she wanted adoration, anticipation of her every need and his complete preoccupation with her. Because he failed to satisfy her, she also hated him. Without realizing it she resented his interest in his work and his interest in their children.

On the one hand she needed her husband too much to leave

him or to hurt him physically, but on the other hand because of the continued frustration of her deep lying needs she was furious with him. She felt that he did not love her enough. Before she developed symptoms resembling heart disease she was having, therefore, trouble with her husband and love. She was indeed having heart trouble in the colloquial sense.

With the development of the symptoms resembling heart disease, she was able to inflict a kind of pain on her husband; he worried about her, the expense of consulting physicians was great, and she was unable to discharge her wifely duties. She also received even greater attention from her husband at the expense of his work and their children. In having to take to bed she virtually became the dependent young girl that she craved to be.

Such strong dependent needs in an adult can never be satisfied realistically we have discovered, and the person who has these feelings always feel cheated. Because satisfaction is not possible, there is always a considerable amount of resentment directed towards the person trying to satisfy the dependent desires. Part of this woman's conflict was: How can I hurt this man who always frustrates my desires and still continue to get love or better, even more love. The development of her symptoms allowed the partial satisfaction of both of these elements: She was hurting her husband; she was getting more interest and affection.

The conflicts and the compromises are continually at work and superimpose themselves on one another. This woman could not allow herself even unconsciously to hurt her husband without atoning in some way. During her heart attacks, which so hurt her husband, she too, of course, suffered severely.

C. Symptoms Judged by Group Standards

Before concluding our discussion of symptoms, it will be wise to recall to mind again the intimate relationship between symptom and culture. The solutions or compromises that people

find for their conflicts are judged by the society in which they live. They are judged by group standards, even though the group as a whole may not be aware of the nature of the compromise.

Certain symptoms have a tendency to occur together and are then given names, diagnoses. Diagnoses are important only statistically, however, for although the prognosis is better for certain entities, a particular case may or may not be amenable to treatment, irrespective of the diagnosis. In addition, the advancement in our understanding of why people—sick or well—think, feel and act as they do has played havoc with the classification of the various psychoneurotic personality types. Careful examination of the various categories has revealed that they are not as separate as was formerly thought and some cases previously considered neurotic might better be considered psychotic.

D. Modern Description of Mental Disease

In the discussion that follows, the modification of the Diagnostic classification of the Committee on Mental Illness of the American Medical Association in most common usage will be used. During the past several years, under the leadership of the Armed Forces, and subsequently the Veterans Administration, a newer nosology has been adopted. This new terminology will be mentioned in the descriptions, for although not yet universally in use, the chances of its widespread acceptance are considerable.

We will divide the neurotic personality reaction types into: Psychasthenia, hysteria, hypochondriasis, neurasthenia and reactive depression.

III. Psychasthenia

Although this term has been very useful in the past, one rarely meets cases today carrying this particular diagnosis. Our more recent advances has made it advisable to break this category down into three separate entities: Obsessive-compulsive neurosis, anxiety hysteria and anxiety state.

A. Obsessive-Compulsive Neurosis

(Obsessive - Compulsive - Ruminative - Tension State; Obsessive - Compulsive Reaction)

An *obsession* refers to a thought and a *compulsion* to an activity that must be repeated in spite of the conscious effort directed against such repetition. They were once thought to exist independently. Although one or the other may predominate, however, they always exist together and the resultant psychoneurosis is called obsessive-compulsive neurosis.

Obsessive-compulsive phenomena have been present in all of us at one time or another. We have all had the experience of having a tune stick in our minds. It sort of keeps humming itself to us. We cannot shake it loose for a while. Usually we are rather amused but sometimes we become annoyed if we are trying to recall another melody. This is the essence of an obsession.

When such a repetitive thought does not disappear, or if instead of a harmless tune, it is a horrible thought such as: What if I were to kill my sister, one can understand how disturbing it can become. Occasionally, in spite of the unpleasantness of the recurring ideas, there is no anxiety. Sometimes the repetitive thoughts are not at all unpleasant in content, but become disturbing only because of their frequency.

In its most severe forms the obsession is so pervasive, normal life is interfered with. A woman forced to think of odd numbers, constantly had to try to arrange mentally the things about her in odd numbered groups. If she happened to be glancing at her fingers, she had to think of them as groups of five, rather than a group of ten fingers.

Compulsive phenomena, too, are probably natural to earlier stages of development. For example, during a certain period, the young child must have his favorite toy in bed in order to go to

sleep easily. All of us have had the experience of starting to step on the cracks of sidewalks, and then when we found ourselves a little bored, discovered it was hard to discontinue this activity. We kept going a step or so more than we comfortably wanted to. Some students must outline their text books, in spite of the fact they never get a chance to review the outline and feel that there is a certain purposelessness to such behavior. Sometimes we feel the urge to wash our hands, have doubts as to its necessity and then end up by hardly wetting them. These are all activities we are obliged to perform almost in spite of ourselves. These are compulsions.

In its most severe form, normal life is interfered with. A certain woman had to spend four hours washing her dishes for it was "necessary" to scrub each dish seven different times before she felt satisfied it was clean.

The following case illustrates the obsessive-compulsive neurosis.

A 17-year old high school boy of bright-normal intelligence was sent to a psychiatrist because he was failing in school. It developed that during the time ordinarily used for study—even the time ordinarily used for paying attention in class, this young chap was forced to use for other things. He found himself constantly preoccupied about how to save enough money from his allowance to help pay his own way through college, though the financial situation of the family did not require this. He discovered the following method: For whatever he spent on entertainment (movies, dances) he would assess himself, from his allowance, 10% of what he spent and put it aside. For every cigarette he smoked, he would charge himself one-tenth of a cent. For every "bad word" he used, he would charge himself one cent a word, for every "bad word" thought of, a half-cent a word.

During the day he would make notes, but during the evening,

he would have to carefully review the day in great detail to see if he charged himself properly. For example, he had to recall how many of his cigarettes were smoked by others so he would not charge himself incorrectly, but also how many cigarettes given him by others he had consumed. Sometimes phone calls were necessary to check up on some of these details. The book-keeping was very time-consuming. He had to make change from his allowance money to his assessment money, write out little chits, and later consolidate them, for the fractions of a cent involved. He had to figure how he could borrow against next week's allowance for an excited epithet uttered during a basketball game. He had to figure to see if he could afford a movie, think about how he could cut down on what he spent for lunches to be able to afford a street car ride home from school, etc.

This young man was very uncomfortable about having to perform all of this and worried about it, but could not stop it, although he felt it was silly.

The overwhelming impulse to steal (kleptomania), to set fires (pyromania), are varieties of this form of illness, in spite of the fact that the courts frequently deal with such severe compulsion neurotics only as lawbreakers.

The chief characteristics, then, of the obsessive-compulsive neurosis are: Thoughts or acts which are contrary to the conscious will that must be repeated, usually, *but not always*, accompanied by tension, feelings of insufficiency, depression and agitation.

The severely disabling symptom-group called obsessive-compulsive neurosis is also a compromise, which partially satisfies both elements of a conflict. For these people, the underlying conflict frequently is concerned with certain unpleasant thoughts or impulses directed against persons whom they also love. The preoccupation with the obsessions or compulsions prevents the emergence into conscious awareness of the unpleasant thoughts or impulses but allows fulfillment of them when the repetitive phe-

nomena hurt others. This is true even when the content of the obsession is unpleasant, for the deeper-lying thought would be even more unpleasant if allowed to emerge with its full force of feeling.

B. Anxiety Hysteria

(Phobias; Phobic Reaction)

When the life of an individual is disturbed by intense and unreasonable fears, we have a condition called anxiety hysteria. These fears, also called phobias, may be of two kinds. The fears may either be of objects or situations which do not ordinarily produce fear in adult people of a particular culture or the fears of the object or situation are much greater than most other people in a particular culture experience.

These strange and excessive fears resemble very greatly the fears that are common among children. Thus there are fears of being alone, fears of being away from home unless accompanied, fears of the dark, etc. When the fears are so great that modification of behavior is necessary to avoid the fear-producing object or situation, we have this type of neurosis.

For example, a young woman was so fearful of being alone on the streets, that she could not go out unaccompanied. Usually, though she was an adult, it was necessary for her to have her mother accompany her. The young woman's life was greatly interfered with by this disorder.

In the very deepest parts of the personality of such people it can be discovered that the anxiety they feel in the presence of some dreaded situation is really transferred from a hidden (unconscious) situation. In essence, the anxiety becomes detached from a specific unconscious situation which is too upsetting for the person to recognize at all, and is displaced to a representative external situation. The emotion of fearfulness remains, but

the object of the fear is altered to an external one which can be thought about, and then avoided. The compromise is effected by externalizing a representative or an element of the conflict and handling it as if it were not an internal problem.

For example, the fear of being alone may represent the fear of doing certain socially unacceptable things, if one were alone and had the opportunity. Instead of a conflict, about whether or not to do something "bad," the problem becomes one of not being alone so that the temptation shall not arise. To be alone becomes a fear-producing situation because the possibility of being bad is greater.

The "socially unacceptable" activity above refers to indulgence in some forbidden pleasure. The inability to tolerate the performing of this forbidden pleasure is an outgrowth of the intimate relationship the person once had with an older person. In a sense the reason the conflict exists at all is because of this other person. The conflict can be abbreviated as: Shall I do this pleasurable thing that has been forbidden to me or not? Shall I do this "bad" thing and thereby hurt this other person or not? The compromise becomes: I cannot do this "bad" thing and thereby hurt this other person so long as I am not alone and have not the opportunity. On the other hand, I can hurt this other person who has forbidden me this pleasure, by insisting that this other person (or a representative) constantly stay with me and keep me "good." In such a phobia, therefore, one usually finds one close person who is particularly involved. In the example above, it was the mother.

There is no complete agreement among all observers as to whether the concept Anxiety Hysteria should be solely limited to these phobic states. Some authors believe that the concept "Anxiety Hysteria" should include the condition Conversion Hysteria (see below) in which anxiety is particularly prominent.

C. Anxiety State

(Anxiety Reaction)

Most of us have suffered from uncomfortable feelings which we find difficult to explain and which seem to be intimately associated with a sort of inner apprehensive expectation. In its more severe form and when it is accompanied by irritability and intense self-preoccupation, we call this condition Anxiety State or Anxiety Reaction. This anxiety is usually diffuse and is variously explained by the sufferer from time to time, first, on this basis and then by that. For example: A man suffering from anxiety may first blame his noisy children, then his sore back and later the weather.

The anxiety referred to is accompanied by any or all of the psychological concomitants of real fear. Therefore, one will find palpitation of the heart, breathlessness, tremulousness, etc.

Since anxiety is so frequently seen in other disorders, one must always carefully consider whether or not the individual involved does not have another form of neurosis or even a psychosis.

When the severe anxiety has been brought about by some catastrophic situation, where the patient has been badly frightened, we can expect that the anxiety will diminish as soon as the person becomes convinced that the danger is over.

In certain cases, however, the anxiety persists for very long periods of time. It becomes chronic. Such persons when they present themselves for help still usually relate their discomfort to a particularly unpleasant experience in the past. It is certainly true in a sense that the accident caused the nervous condition, but how can we understand the persistence of this fearfulness even years later, when the reality danger has passed.

What seems to happen in these cases is that the frightening experience reinforces certain hidden (unconscious) fears the person has had for years which have grown out of his entire life

experience. It is as if the accident reignites the pent-up insecurities accumulated through the earlier years of his development. Treatment then becomes more than dealing with the anxiety of the precipitating experience. It requires consideration of things pre-dating the apparent catastrophic cause.

IV. Hysteria

(Conversion Hysteria; Conversion Reaction)

A. Conversion of Inner Conflict to Body Parts

Some people when faced with the difficulties of maturing, the demands and responsibilities of reality and the frustration of strong inner desires, are able to deal symbolically with their deep-lying conflicts by the development of bodily symptoms which resemble true organic illnesses. Such a conversion of inner conflicts to bodily representations occurs without the person so involved realizing it. This condition is allied to the concept of psychosomatic medicine. (cf.)

The various presenting complaints of persons with conversion hysteria are often hard to differentiate from organic illnesses. There may be hysterical blindness, deafness, paralysis, pain, anaesthesia, convulsions, etc. It descriptively differs from hypochondriasis (see below) in that there is usually only one bodily complaint.

Formerly neurotic difficulties which resulted in symptoms referable to the body systems (digestive, circulatory, respiratory, etc.) were not grouped with the neuroses. Because they so closely resemble the hysterias, however, we will list them here. The newer terminology groups them in a separate category called somatization reactions.

B. Symptoms Avoid Anxiety

In a sense the symptom of the physical illness that such people develop is an attempt to avoid anxiety and in those cases where

the conversion to bodily complaint is especially successful, the person has no anxiety even about the most distressing physical symptoms. It is as if these people thought within themselves: "I am not too distressed about my paralyzed arm. It is much preferable to the anxiety of facing some hidden conflicts of mine. It is a good compromise." The relative indifference such people often have to their physical complaints is striking and characteristic of this kind of personality. Sometimes, too, the onset of symptoms seems to have a dramatic quality.

C. Amnesia

We have stated that the development of the conversion is really a way of avoiding anxiety feelings about certain conflicts. It is a kind of withdrawal. When people, without being aware of it, run away from their conscious or unconscious problems by forgetting who they are and what they are, we have a condition called amnesia. Because of the similarity in the method of development of the conversions and the development of amnesia, they are usually grouped together under the heading hysteria. The newer terminology classifies amnesia with the related condition of trance state and calls them the dissociative reaction.

Following is a case of amnesia: John Jones had been assigned, with a machine gun, to cover a certain path leading from the jungle into camp, and for security reasons had been placed 200 yards down this path on a little bluff. During his two-hour watch, he could hear a thousand times in the wind's rustling, the seemingly stealthy approach of the enemy. Once he imagined one had gotten behind him and at any moment would knife him. He prayed the time would pass quickly but it did not. He wondered if he might lose control of himself and just leave the gun and run back to the relative safety of camp. No, he couldn't do that. It would be better to be killed than to be "yellow" or desert his post; but such conscious decisions, such belt-hitching hardly re-

assured him. He even wished he was somehow sick. His right side did hurt him . . . maybe he had appendicitis. If he had appendicitis, he could go back . . . but the pain in his side disappeared and he knew that couldn't work. He just couldn't desert his post, not he, John Jones. It would lead to a court martial; worse, it would leave him ostracized for the rest of the war, maybe for his whole life.

A few moments later, he became aware of the wallet in his back pocket. It pressed into him, the way he was sitting. He didn't immediately recognize it as a wallet. He reached back and was sort of surprised to discover it. He wondered where it came from. He looked at the name imprinted on it in the light of the moon. It said: John Jones. He was startled. Now, he wondered just how the devil did someone else's wallet get in my pocket. Did he steal it? No, he knew he didn't. Maybe the others, if they heard about it, would think he had. He'd better return it. He didn't know a John Jones, though. He better turn it in to the Lieutenant, he felt.

This meant leaving his post. But that wallet might be important to someone. So John Jones left his post to return a wallet, which he felt did not belong to him because his name wasn't John Jones. He didn't know his name, but he knew, surest of all, it was not John Jones.

The conflict John Jones faced was: How can I run away from this dangerous situation and still not lose face. A compromise was effected when he lost his identity for then running away became possible since it was not John Jones who was fleeing.

The piling up of conflict and compromise one on another is of particular interest here. Once the amnesia had developed, so that running away became possible, one might expect that John would just leave his post and go off somewhere. By the development of the concern about the "found wallet," however, he turned himself in, on the one hand as a "deserter" and on the other as

a messenger to his C.O. on the ground that the outpost was not covered and the safety of his fellow soldiers was in danger.

The great majority of faith cures and the dramatic improvements associated with unorthodox non-medical treatment usually are cases of hysteria for such symptoms are by and large readily influencable by suggestion. The prognosis for this form of mental illness is quite good.

The choice of what particular symptom a patient develops can frequently be understood in terms of his earlier experience. Sometimes the choice is purely a psychological one—that is, the organ involved has a particular symbolic meaning in the vast early life experience of the person. Sometimes, it seems, an organ is chosen because of an actual weakness or malformation which seems to serve as a readily available peg on which to hang symptoms.

V. Hypochondriasis

(Hypochondriacal Reaction)

All of the activities of which the newborn infant is capable can be understood as egocentric in character. His energies are particularly directed at self-preservation. As he grows older, part of his energies are directed toward his environment, especially to the people about him.

When psychological development proceeds without interference, such an alteration of the disposition of energies or interests of the individual takes place. In the face of certain crucial or repeated disappointments, a great degree of self-interest can persist. The body, its parts and functioning, remains of prime interest.

Hypochondriacs, without being consciously aware of it, are really persons whose main interest is the welfare of their own bodies. This preoccupation is so great that in the little normal interruptions of the rate of breathing or pulse, or in the fleeting

pains that we all have, they feel a considerable threat to their welfare or to their very existence. They then wonder whether or not it is tuberculosis or cancer that troubles them.

These people are extremely uncomfortable and their suffering is bona fide although frequently they are not treated sympathetically. Particularly characteristic of such persons is the variability of the parts of the body that interest them so that the complaints of the disease they feel they perceive quickly shifts from organ to organ, and in one way or another, tells you—its the whole body that concerns them.

Hypochondriasis is relatively benign. No one ever died of it. But just as a headache can be due to eye strain or a malignant brain tumor, so one must carefully consider whether certain cases of hypochondriasis are not really in the early stages of schizophrenia, which sometimes starts out with symptoms resembling hypochondriasis. It is possible hypochondriasis should be considered only a symptom rather than a disease.

The kind of physical suffering hypochondriacs undergo is illustrated by the following list of symptoms mentioned over a period of several months. Physical examination showed no abnormalities.

1. Knife-like pain in the chest.
2. Pain in the right ankle.
3. Locking feelings in the left knee.
4. Pain in the left side of the abdomen.
5. Pain and stiffness of the back.
6. Indigestion and heart-burn.
7. Pain in the right heel in the mornings.
8. Vague discomfort in the hips.
9. Whirling feelings along the skin of the chest.
10. Headaches.
11. Weakness of the hands and arms.
12. Pain in the neck.

VI. Neurasthenia

(Asthenic Reaction)

Neurasthenia was a term introduced about a century ago to describe a condition of excessive fatigue, not explainable on the basis of careful physical examination and manifested by weakness in doing physical or mental tasks, irritability, preoccupations with bodily complaints similar to hypochondriasis with an overtone of mild depression.

In recent years, one no longer finds this particular disease diagnosed very frequently. This term too is perhaps better thought of as a symptom rather than an entity. More careful examination of such people often shows them to have a different psychiatric diagnosis. Some of these people turn out to be schizophrenic people, some hysterical people, etc. The fatigue—which is the outstanding feature is an exaggeration and more prolonged kind of tiredness that all of us can feel on occasion. It is a kind of exhaustion. If ever you have spent hours trying to figure out some kind of problem, only to have to give up because you couldn't solve it, yet still feel a solution was absolutely necessary, you have been able to feel a little of what such a person goes through most of the time. Some observers feel that a chronic problem, which the person is unaware of, depletes his energies just as work on a conscious problem would.

VII. Reactive Depression

To feel sadness, to weep over certain depressing conditions such as sickness or death is certainly sufficiently common to human beings to be considered within the normal realm. When in response to external conditions which normally produce sadness, the depression is more severe and of longer duration than is commonly seen, we speak of a Reactive Depression.

All depressions must be compared with the psychotic depression of manie-depressive psychosis, and some cases that seem at

first to be simple depressions turn out to be this more malignant type. This is especially the case if there is considerable tension with the depression.

These people usually avoid anxiety by the development of the depression. Along with the depressed feeling they express ideas of self-depreciation which are often associated with feelings of guilt about past deeds.

VIII. The Normal Development of the Child

In order to understand why a specific neurosis develops, it is necessary to understand something about the normal development of the child. Although this extensive subject cannot be treated in detail here, it would be well to indicate something of what takes place.

Just as the key to understanding why one person becomes neurotic, and another not, lies in the earliest years of life, so it is with the kind of neurosis developed. The hereditary-constitutional factors with which the infant enters the world includes not only those previously mentioned, but certain instinctual drives. The new-born, for example, already knows how to breathe, to heal his wounds, to suck nourishment, etc. Just as surely as the infant will tend to enlarge physically, so it will tend to develop psychologically.

During the earliest weeks of life, it is completely dependent on others and preoccupied only with its own desires of being fed, of being able to breathe, and of being warm. The earliest thinking and imagery formation have to do only with the satisfaction of such wishes. Soon the infant connects the presence of the mother with the satisfaction of its tensions and becomes interested in her. Reality has on meaning for such an individual, for its mind is preoccupied only with its personal needs.

The earliest thinking is magical in nature. The child thinks strong desires will always be met in some way. This seems to

develop out of the fact that the child is periodically concerned with being attended to in one way or another and if enough time elapses during this period when its wants are limited to food and warmth, the mother eventually gets around to taking care of them.

Just as the self-preoccupation gradually gives way to include interest in the mother, so the dependency becomes less absolute. With the development of minimal independence, some of the tensions the infant has are relieved by himself or at least more quickly. This perhaps stirs his interest to achieve more mastery. As this goes on, reality has to be reckoned with and inquisitiveness develops perhaps largely in response to complete mastery over a certain part of reality.

The various experiences to which the growing child is exposed will effect the child differently depending on what his facilities are for reacting. In other words, where the child is, in the above briefly outlined scheme of development, will influence to a considerable extent how he will react to what happens to him. In the earliest days, he can protest late feedings only by rage, but later he can ask for food and still later procure some himself. In the earliest days, he can "run away" only by sleeping, but later he can do so physically.

As soon as learning is possible, (and indications are that learning is possible from the very earliest days), previous experiences, the infants reaction to them and the degree of goal achievement (tension relief) that occurs will serve as a readily available pattern with which to handle future similar episodes.

It is not only the reactions to casual experiences that determine the personality of the adult. There is another factor that complicates the development. The child without learning first identifies itself (imitation without conscious awareness) with one parent, then the other. In those instances where the proper parent is not available, or the parent is peculiar, distortion in emotional development can occur.

Consequently, the effect of a particular experience depends

upon the psychological facilities the child has at its disposal, as modified by his reaction to previous and similar situations, and as influenced by the nature of his identifications.

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Chapter XIII

NEUROTIC REACTIONS IN WORLD WAR II

By SAMUEL PASTER, M.D., F.A.P.A.

Memphis, Tenn.

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The transition from civilian to military life involves a radical departure from the accustomed way of living. War brings about sharp changes in human values. It emphasizes the needs of a group rather than those of the individual. It brings about changes in attitudes and habits and forces a man to act in a way that he would not have dreamed of in civilian life. The emotionally unstable, exposed to the great stresses of war, are particularly vulnerable.

Cognizant of these facts, the military and civilian leaders who were the major forces of the volunteer movement and who set into motion during World War II a voluntary movement designed to provide the individual with the correct forms of emotional and social contact. One hundred and twenty-eight out of a total

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SARAH F. PASTER AND J. A. PASTER

Philadelphia, Penna.

Chapter XIII

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By **SAMUEL PASTER, M.D., F.A.P.A.**
Memphis, Tenn.

1. Transition From Peace to War

Our psychic equilibrium is maintained by the dynamic process of adaptation of our instinctual drives to social demands. In peacetime, the structure of society is sufficiently elastic to allow each individual to seek, through personal effort, a level of adaptation peculiar to his native endowment and his basic needs. Patterns of behavior are established which aid one to maintain his niche in life and lead to the development of a sense of stability and security.

The transition from civilian to military life implies a sudden departure from the accustomed way of living. War brings about abrupt changes in human values. It emphasizes the needs of the group rather than those of the individual. It brings about radical changes in attitudes and beliefs and leaves no room for self-preoccupation. These changes require flexibility of character. The emotionally unstable, exposed to the great upheaval, do not fare well.

Cognizant of these new demands and their possible effects upon the mental health of the inductees, military authorities set into operation during World War II a screening process designed to prevent the induction into the armed forces of emotionally unstable candidates. One hundred and seventy-eight out of every

thousand men called up by the draft were thus rejected as mentally unfit for military service. Notwithstanding this screening process, the rate of discharge from the Army for mental disability was much greater than that incurred in World War I. Close to 1,000,000 soldiers were released from the Army during the war for psychoneuroses and other behavior disorders.

Army life appeals to certain inductees. It offers them an escape from the monotonous struggle for economic survival. It frees them from the colorless daily routine and provides excitement in an ever changing environment. To many the organized effort of a vast number of people constituting the Army has a peculiar psychological appeal. There is the promise of adventure, an upsurge of a sense of power born of the identification with the group and confidence-inspiring leaders. The thrill of advancement and glory satisfies unconscious needs that men have not been able to fulfill in civilian life. War offers displacement outlets for innate hostility and provides the testing grounds for inner strength and self-confidence. The most important factor, however, that impels soldiers to fight is the realization that their country is in danger and their dear ones imperilled.

Many factors undermine the soldier's morale and tax their resistance. The sense of isolation that results from the sudden departure from one's family is often reflected in the soldier's mood. Where the motivation is poor, bitterness and restlessness become manifested early and give rise to emotional upheavals and delinquency. Army life is geared to promote the welfare of the group. Individual initiative and spontaneity are incompatible with an efficient military organization. Submission to authority and discipline, especially where the commanding officer is lacking in the qualities of leadership, gives rise to resentment and hostility.

For twenty odd years, during the interval between the two world wars the American youth, in contrast with the younger

generation of the totalitarian states, had been inculcated with the ideals of the sanctity of human life. Overnight these men were forced to discard the traditional ideal of peace and accept the very opposite ideology of war. The gruesome mission concerned with destruction of human lives precipitated anxiety and feelings of guilt. In many these new demands gave rise to a feeling of cynicism and bewilderment and often led to self-abandon in alcohol and license.

Actual participation in combat brought forth new stresses. The instinct of self-preservation, the will to survive were taxed to the extreme. The weapons employed in the second World War were of greater destructive power, and the methods of fighting, especially in the jungle, were more terrifying. Adjustment to combat conditions involved not only the acceptance of the idea of destroying human lives but the ability to tolerate extreme personal deprivations and danger. These demands corroded the personality of the soldier and gradually undermined his resistance.

Most of the combat participants were imbued with intolerable fear. This fear was intensified by the feeling of frustration that resulted from being pinned down for hours and days, helpless in the face of continuous assault by the enemy, the sense of isolation and impending doom experienced when one's unit was cut off from the main force, and the deadly accuracy of destructive weapons employed by the enemy. Guilt feeling was often precipitated by one's own unbridled instincts which led some men to destroy enemy lives beyond the call of duty. The soldiers were often overcome by depressive feelings and imbued by a sense of futility when they witnessed the plight of dying comrades, the death of the commanding officer, and the sight of dead civilians, especially women and children. Friendly attitudes by the enemy often gave rise to an instinctive feeling of kinship with a group that shared the soldier's tribulations and danger. Prolonged

exposure to combat, fatigue, hunger, sleeplessness, and disease further taxed the soldier's resistance and diminished his motivation to fight.

In the face of the terrific external danger and internal agony and despite their unswerving loyalty toward their friends who fought beside them or who had already fallen behind them, many soldiers were finally overcome by an overwhelming, passionate desire to live, to get away from it all, to escape. Under the continuous impact of anxiety, they began to show signs of disorganization of the ego defenses. They became restless, irritable, explosive and extremely sensitive to noise. Their sleep was disturbed by tormenting nightmares in which they again and again relived their traumatic experiences. Many began to manifest signs of dependence. Some became retarded and seclusive; others became hyperactive and indulged in excessive verbalization. One could see these men at the battalion aid station especially after a heavy engagement with the enemy, trickling in, tense, tired, tremulous, overwhelmed with discouragement and fear. Some were confused and amnesic. Their speech was often impaired, ranging from stuttering to complete mutism. Many complained of organ dysfunctions such as palpitation of the heart, vomiting, and diarrhea. Functional paralyses, hysterical deafness, blindness, and epileptiform seizures were not infrequently encountered.

It is commonly believed that the soldier gladly succumbs to his symptoms. Those who have had the opportunity to study these cases found the contrary to be true. Many of the soldiers made desperate attempts to overcome their symptoms as was witnessed by the readiness with which they returned to the front following a brief period of rest at the battalion aid stations. When their symptoms had not been relieved in time, the personality of the soldiers so affected underwent greater disintegration. Many of those who had deliberately concealed their symptoms so that they

might remain with their unit finally began to manifest savage outbursts of fury. They climbed out of their foxholes with complete disregard of danger. Sobbing and screaming, they fought aimlessly and wildly. Others became completely retarded, withdrawn, mute, and inaccessible.

At the battalion aid stations, these men were offered warm food, sedation, and sleep. Many of them were able to return to the front twenty-four to forty-eight hours later. Those who did not recover promptly were sent further back to the exhaustion centers. There they were again assorted and treated. Within ten days a number of them returned to the front, but the majority remained incapacitated and were sent further back to general hospitals.

In contradistinction to the traumatic neuroses incurred in peacetime, war neuroses were not the result of sudden, non-anticipated catastrophe. Neurotic reactions incurred in combat were the result of accumulated, terrifying experiences that gradually undermined the resistance and disturbed the equilibrium of the ego defenses. To understand the deeper implications of war neuroses, it is necessary to analyze the basic structure of the personality and review the interplay of its component forces taking part in the process of the adjustment of the individual to his environment.

The newborn infant is at the mercy of his instinctual demands. Under the educative and restrictive influence of his parents, he gradually develops inhibitions by means of which he is able to curb his destructive impulses and develop socially acceptable patterns of behavior. The inhibitory influence of the parents gradually molds the character of the child. At first imposed externally, the paternal restrictions become in time an integral part of his psychic apparatus. Thus internalized, this regulatory component constitutes the conscience or the superego of the individual. The influences of the parents are supplemented later by the

teacher, the minister, and the various socializing agencies of the community at large.

In war, society lifts the prohibitions concerned with the regulation of the instinctive aggressive forces. The new sanctions weaken the superego considerably. The individual no longer views his conscience as the automatic final criterion of his behavior. The conscience becomes once again partly externalized as the military authorities, not the parents, assume the regulatory functions of the individual's actions. The individual's sense of security becomes undermined as the external authority, unpredictable and arbitrary, supplants the automatic function of the conscience. The soldier begins to depend on his officers as he once depended on his parents. Where the commanding officer inspires confidence, the individual soldier feels comparatively safe. Where the commanding officer is injudicious and lacks the qualities of leadership, the soldier becomes imbued with a sense of insecurity and fear akin to the panic experienced by an abandoned child.

The regression to the level of the child is accompanied by the release of long forgotten conflicts. The old Oedipus relationship may be reactivated. The hostile impulses originally directed toward the father may now be directed toward the enemy. Where the attitude toward the father had been ambivalent, the love component may be directed toward one's commanding officer and the hate component toward the enemy. Such relationships are at best precarious, and when the commanding officer behaves in an injudicious manner, he may easily assume the role of the hated father. Under such circumstances, the hatred may cause an upsurge of a feeling of guilt which, in turn, may precipitate a depressive reaction. Senseless and reckless exposure to the enemy may be explained on the basis of this guilt feeling: the unconscious wish to atone and to be killed by the hated father. Where the commanding officer has been incapacitated or the group deci-

mated, the individual who is emotionally no longer an adult may not be able to assume an independent existence any longer.

II. Treatment of Psychiatric Casualties

From the point of view of treatment, psychoneurotic reactions precipitated in combat can be roughly divided into two groups: those that resulted from prolonged exposure to danger, the elements, fatigue, exhaustion and disease; and those in which intolerable internal conflicts arose from reactivated neurotic patterns, the result of a clash between deeply ingrained concepts and radically new demands. The two groups are, of course, not clearly demarcated and, in fact, share one factor in common: a conflict between the sentiment of self-sacrifice for the group and the forces of self-preservation, leading to compromise-formation, regression, and various degrees of personality disorganization.

The personality changes of the patients in whose illness the factors of the first group predominated were not generally great. They were often easily reversible with the application of the comparatively simple forms of treatment such as rest, food, and sedation. Following a course of brief therapy, many soldiers were able to overcome their panic reactions, regain emotional equilibrium and return to the battlefield. Where deeply ingrained neurotic patterns were reactivated, the application of prolonged, intensive psychotherapy was required. Soldiers who had been so severely affected, unable to carry on their duties overseas even in limited service, were evacuated to the States.

When the patients arrived in the States, they no longer manifested symptoms of acute fear. By the time of their arrival their symptoms had become somewhat fixed and assumed a new function. Prolonged anxieties became elaborated into neurotic defenses. Consciously and unconsciously they became of value as a means of escape from danger and impending death. The patients were tense and were preoccupied with their personal problems

to the exclusion of everything else. Their thinking reflected feelings of insecurity and distrust. A regressive trend was evident in their attitudes, the preoccupation with their symptoms and the accompanying diminution in their sense of social consciousness.

In an attempt to counteract the deteriorating influence of hospitalization upon the patients, an extensive program of recreational and athletic activities and occupational therapy was initiated in the Army hospitals in the Zone of the Interior as early as 1942. These activities proved themselves of great value in that they helped to maintain a cheerful atmosphere and stimulated the patients to constructive effort.

It became apparent quite early in the war, however, that this program as such fell short of reaching the roots of the problem since the attitudes and the symptoms, which had rendered these men ineffective as soldiers, remained unchanged. These patients had lost their self-confidence and sense of security. They were tired, anxious, and unhappy. They resembled frightened and helpless children who, having lived through terrifying experiences, looked for affection, security, and, above all, rest. But many of them could not rest. They were tortured by a sense of guilt for having killed human beings and felt that they had betrayed their buddies who were still fighting on. They attempted to cast into the depth of the unconscious the terror and emotional upheaval that filled their minds, but with little success. In addition, in view of the stigma attached to mental illness, they felt ashamed and were afraid on their return to face their families and friends. Unable to solve the inner conflict, they were irritable and resentful. Their tension kept accumulating and, like steam that is not permitted to escape, often broke through at the least provocation and resulted in explosive behavior.

In an attempt to formulate methods of treatment of the battle-incurred neuroses, several factors not encountered in peacetime neuroses had to be taken into consideration. Most of the patients

did not seek help. They lacked motivation to get well inasmuch as the persistence of their symptoms afforded them adequate protection from the impending threat of being returned to combat. Rooted in some cases in factual, unhappy experiences and in others the result of projection of personal inadequacy, a thick crust of resentment, grievances and distrust had been added to the original core of neurotic manifestations.

Psychotic, especially disturbed and suicidal patients were on arrival promptly placed under close supervision. They were made comfortable, bathed, fed, and reassured. They were examined by ward officers who upon admission outlined a plan for individual workup, ordered proper laboratory tests, prescribed proper care, and initiated correspondence with their nearest relatives.

During the first months of the upheaval, the War Department relegated the treatment of psychotic soldiers to state hospitals or to Veterans Administration facilities. This policy was changed as a result of the influx of a large number of patients into Army hospitals and the inadequate facilities offered by the Veterans Administration and civilian institutions. Many of the Neuropsychiatric Services of the Army hospitals instituted insulin treatment of psychotic patients and were later given permission to employ electroshock treatment. Psychoses precipitated under the stress of combat conditions were shown to have a better prognosis than those occurring in civilian life. One-third of the psychotic soldiers admitted to the hospitals from various theatres of war fell into the group of acute schizophrenic reactions. Most of these patients recovered spontaneously following their removal from the zone of danger. Approximately one-fifth of the psychotic patients continued to improve slowly under the socializing atmosphere of the various hospitals. A considerable number of patients recovered or improved as a result of shock treatment and were enabled to resume a useful existence in civilian life.

The overwhelming majority of the mentally-ill veterans were

not psychotic. A comprehensive program of treatment of psychoneurotic soldiers was set into operation in Army convalescent hospitals under the direction of Brigadier General William C. Menninger. In order to relieve the tension manifested by the large numbers of these patients, group psychotherapy was instituted in many hospitals. During group treatment an attempt was made to encourage the patients to talk freely about their combat experiences, thus affording them the opportunity for the much needed emotional release. Each participant was called upon to relate the experiences which led to the development of his nervous symptoms. The symptoms of each patient were then discussed. Their meaning was explained. The patients were urged to talk freely and to learn to face their memories courageously instead of repressing them. Repeated attempts were made to allay their anxiety, to overcome their guilt feelings, resentments, grievances, misconceptions, and to restore self-confidence. An attempt was made to analyze their main conflicts and to eliminate their morbid fears. The patients were taught to regain independence and to abandon the need for emotional support. As the treatment continued, the patients' attitudes of suspicion and reserve tended to disappear. Greater trust and friendliness became evident in their demeanor. The terrifying nightmares receded. Their morbid fears faded away, and they began to face their terrifying memories with composure and equanimity. As a result of group treatment, a considerable number of the neurotic soldiers were enabled to return to non-combat duty. Most of the Army psychiatrists felt, however, that it was unwise to return any of these men to the battlefield.

Depressed and extremely anxious patients, overcome with guilt feelings and a sense of self-depreciation were often offered narcoticsynthesis. Sodium amytal or pentothal were administered intravenously until a state of partial somnolence was achieved. Under the influence of the drug, the patients frequently re-

enacted their battle experiences and achieved a release of their pent-up emotions. Violent outbursts were not uncommon during this treatment.

Deep narcosis was often employed both near the front and in the Zone of the Interior to insure continuous sleep. In the course of this treatment, the patients were kept in a state of complete repose as long as ten days or more. They were kept comfortably warm, usually in a dark room. The patient slept on his side and was turned to the opposite side every two hours. His head was lowered so that he would not aspirate the accumulated secretions. He was awakened sufficiently at mealtime to enable him to eat and attend to his natural needs. Blood pressure, pulse, and respiration were checked frequently. This form of treatment was of great benefit to those soldiers who had suffered from prolonged exposure to combat and the elements.

Many psychiatrists employed hypnosis, especially in the cases of conversion hysteria. Trances were induced in all these cases, and the hypnotic state served both for abreaction and reintegration of the personality. Many hospitals employed psychodrama, in which the patient, aided by professional workers, was enabled to re-enact the conflicts that bothered him most.

III. Post-War Neuroses

While the war continued all of the efforts of the Army were concentrated on maintaining an efficient military force. The reconditioning program was geared to salvage as many men as possible in order to render them once again useful in one capacity or another in the scheme of military defense. With the cessation of hostilities many new problems arose. The Army hospitals began to close one after another and the burden of care and treatment of the mentally-ill veterans was shifted to the Veterans Administration. It was discovered at this time that in addition to the psychoneurotic soldiers, many men who had

been discharged from the Army "on points" without any mental or physical disability were unable to adjust to civilian life. They began to report to the mental hygiene clinics seeking help. They complained of being irritable, restless, and unable to get along with their families and friends. Many of them claimed that they were too nervous to hold on to their jobs. They were still haunted by memories of disease, exhaustion, and the prolonged grip with death. They remembered reading about the lucrative jobs at home and now, faced with the complete indifference of the civilian population, they felt unwanted and betrayed. The Army had deliberately trained them to reactivate their latent aggressive tendencies and when they returned home they were still aggressive, irritable and restless. The grim determination with which they had fought in battle was still with them. Yet having been deprived of their individuality and personal incentive, they were bewildered and filled with indecision and doubt. The very atmosphere of the home previously seeming so unattainable and alluring, seemed, after years of strain and excitement, disappointing and dull.

These men became intellectually mature in a brief span of time. Emotionally, however, many of them regressed to a level of behavior usually characteristic of the adolescent period of growth. They developed definite character changes. At times, as a result of deeply rooted hostility but more often as a result of pent-up emotions, they were quick-tempered and explosive. They quarreled easily. They were often self-accusatory and experienced a feeling of guilt for real or imaginary failures. They tended to project their sense of failure into others, especially those civilians who had not served in the armed forces. They were, in turn, friendly with one another and preferred each other's company. As long as these men had lived under the stress of great danger, these characteristics had been of great value to them. It was obvious, however, that it was quite disadvantageous

to maintain such attitudes in peaceful surroundings. Most of the veterans realized this and strove to regain a normal outlook on life. The majority of the so-called normal soldiers had achieved satisfactory adjustment with a minimum of aid. The speed with which they regained normalcy depended upon their basic personality structure, the degree of disorganization sustained by them, and the presence of external factors favoring recovery.

The number of combat veterans who have been unable to harness their impulses upon return home is quite large. In many of them the intense emotions activated by inner conflict and feelings of guilt in relation to battle experiences have become displaced. They have become associated with new patterns of behavior constituting the core of chronic neurotic reactions. These emotionally-charged patterns of behavior foster insecurity and distress. In some individuals the residual anxieties related to battle experiences have led to the beginning of uncontrollable indulgence in alcohol and concomitant disruption of family ties. Their tension and restlessness has affected their relationship with their wives and their social and occupational associates. Regressed to a stage of adolescence, these men are actually competing with their children instead of helping them to grow.

It is because of these morbid potentialities that psychiatric aid has become an imperative part of the process of rehabilitation of the mentally-ill veterans. The Veterans Administration, cognizant of the magnitude of this problem, has established a Medical Rehabilitation Service. This Service offers every psychologically or physically wounded veteran the opportunity for mental, physiological, social and economic rehabilitation. The problem of physical and psychological rehabilitation is woven around one principle: to help the patients regain confidence in themselves. Both the psychoneurotic and the psychotic patients are offered in the Veterans hospitals a program of treatment designed to reintegrate the patient with life around him. Each pa-

tient is given the type of treatment most suitable for his case. This ranges from individual and group psychotherapy, narcosynthesis, and hypnosis for the neurotic, to narcotherapy, electroshock, and insulin treatment for the psychotic. In the afternoon following treatment, the patients are directed into various activities, such as occupational therapy shops, swimming pool, gymnasium, or pre-vocational shops. In the evening, under the supervision of Special Services, they participate in dramatic activities or are offered entertainment by various volunteer groups.

Following the termination of specialized treatment, both the neurotic and psychotic patients are transferred to special rehabilitation wards. There the psychologists subject them to a battery of tests designed to determine their level of intellectual function, the degree of emotional stability, and their vocational aptitudes and interests. The patients are then sent to respective shops where they can choose for themselves the type of work they wish to do and, most important, find out whether they are capable of doing such work. Each man may later supplement his pre-vocational experiences with "on-the-job" training. He may pursue various courses of study ranging from locomotive or radio repair, watchmaking, printing, photography, plastic and metal work, and the arts, to subjects such as English, social studies, typewriting, bookkeeping, etc. Upon discharge from the hospital he may, through the close cooperation with local schools and universities, further his educational program along lines most suitable for him.

One of the most important phases of the rehabilitation work is accomplished by the Social Service Department. In many hospitals the social workers, under the supervision of the ward doctors, conduct group discussions with the patients in an attempt to orient them to the social problems they will face on return to their respective communities. The social workers investigate

the economic setup of the veteran's family. They hold conferences with the immediate members of the family, advise them concerning the nature of the patient's illness and counsel them with regard to their attitude toward the patient. This information, given to the relatives, is of crucial importance. The psychoneurotic and the psychotic patient have one characteristic in common: preoccupied with their symptoms, they tend to slump into chronic inactivity. Both must be encouraged to become interested in the world about them and resume some constructive activity. They differ from each other, however, in that while the nervous veteran can eventually regain the capacity to work he possessed before the war, this may not be the case with the man who suffered a psychotic reaction. The veteran who has recovered from his psychosis may also attain a satisfactory adjustment. His relatives, however, must be on their guard and should not urge him to reach beyond his ability.

Prior to his discharge from the hospital, the patient is examined by a board consisting of a psychiatrist, psychologist, and social worker who, on the basis of their assembled information and the patient's prevocational record, make proper recommendations concerning his further training. Following the discharge of the veteran from the hospital, the Social Service Department continues, in many instances, its contact with the social agencies of the veteran's respective community in order to promote their efforts to adjust the veteran to his family and his work. For those veterans who are able to work but who still need the help of a psychiatrist, mental hygiene clinics have been made available.

How the team consisting of a psychiatrist, psychologist, and social worker functions is illustrated in the condensed accounts of the following two cases:

Case 1. The patient, a twenty-five year old former lieutenant in the infantry, was referred to our Out-Patient Department by a private physician. He appeared tense, anxious, and depressed.

He spoke rapidly and complained of intense pain in his heart accompanied by a sense of panic and a feeling of impending death. These symptoms appeared about two months after he returned from the Army.

Physical examination revealed a well-developed and well-nourished individual of athletic build. Thorough studies of his heart disclosed no abnormalities. His story was as follows:

He is an only son. His father, a stern and domineering individual, is a salesman. His mother is gentle and submissive. The patient has always been afraid of his father but is extremely attached to his mother. Prior to entering the service, he attended a liberal arts college. He entered the Army as an enlisted man, rose rapidly and was promoted to a lieutenant on the battle-field. He participated in some of the toughest campaigns in the Pacific but escaped apparently unscathed. Although he was all keyed up, he was very happy when he returned home. The very night he returned his father handed down the decision that the patient was going to be a salesman and told him that he had already assigned a territory to him. The patient never liked selling but obediently submitted to his father's will. He felt very unhappy and following several weeks at work failed completely to make any inroads into his father's business. He was tempted to revolt and abandon his work but feared the violent arguments of his father. He toyed with the idea of leaving the family but had great conflicts concerning the fact that he would have to leave his mother. It was at this time that he began to experience the pain in the region of his heart and recurrent attacks of anxiety. As a result of these attacks he was compelled to quit work.

During the psychotherapeutic interview, the patient gained insight into the factors that motivated the development of his symptoms and gradually regained his composure. He was then referred to the psychologist who reported that he had an I.Q. of 140. He revealed a predilection for computational, scientific,

and literary achievements, and scored lowest on the vocational aptitudes concerned with extroversion, persuasiveness, and ability to form social contacts. A conference was then held with the patient in which all the assembled material was reviewed and his personality traits and potentialities evaluated. It is hardly possible to describe the change in the patient's demeanor following the completion of the workup at our clinic. His symptoms abated. He no longer appeared bewildered. He claimed to have gained a sense of direction. He resolved to leave his home and enter college with the determination to pursue the study of biological sciences and with the hope that he would ultimately become a member of the teaching staff of a university.

Case 2. A thirty-one year old veteran was admitted to our hospital from the city jail. He appeared restless and spoke in a flighty and grandiose manner. He said that he was a salesman and declared that he had been very successful. He boasted that he had studied medicine, law, and business administration. He declared that he did not love his wife and that he firmly resolved, despite the fact that he had two children, to obtain a divorce from her.

His wife was interviewed. She stated that he had been an ideal husband, devoted father, and a good provider before he entered the Army. She said that on his return home, he appeared jittery, restless, and could not sleep. He resumed his work early and did very well financially. She noticed, however, that he was not the same. He began to stay away evenings and frequently returned home in an intoxicated state. He began to neglect his work and became utterly irresponsible. The wife was told by some friends that they saw him in the company of other women. Violent arguments ensued, but he could not be brought to his senses. Following a drunken escapade during which he began to threaten her life, the wife called the police who arrested him and took him to jail. After consulting her family, the wife decided

to divorce him. The police, meanwhile, transferred the patient to our hospital for mental observation.

Following a period of several days in the hospital, the patient's mood changed from that of elation to a profound depression. He became self-accusatory, admitted that he had been drinking heavily, and claimed that alcohol helped him to submerge the horrible memories of war. He said, "My nerves tied me up. I fly all to pieces. At night I get up and walk and walk. . . . I want to live, if I could only forget all that. I can't enjoy myself. I just want to keep going . . . keep going. I know we had to kill them or they would kill us. It had to be done. But it bothers me during the day and I hear them at night. They holler and holler and scream and pray and cry. . . . A lot of my buddies started drinking and I started, too. But even drink doesn't help me. Please don't tell anything of what I have told you to my family."

The patient was treated several months, regained his equilibrium, realized that he had been mentally ill, and was finally reunited with his family. A conference between the social worker and his employer resulted in the patient's return to his job.

IV. Summary and Conclusions

The Selective Service records of World War II reveal that a considerable proportion of the civilian young men suffer from various neuropsychiatric disorders. Despite the screening process at the time of induction, the number of neuropsychiatric casualties in the Army was astonishingly great. Studies made at the battlefield revealed that some individuals who were displaying signs of emotional instability were nevertheless well able to bear the great stress and strain while others were succumbing rapidly in the face of mild or moderate pressure.

In all cases unconscious mechanisms were undoubtedly at work. It is of interest, however, that the tendency to escape, to "give

up" often ran parallel to a background of poorly integrated family relationships during the early formative stage of the development of these individuals. Men, who as children had been reared by stable and loving parents, faced with greater ease the problem of personal sacrifice than those whose early childhood had been characterized by deprivations.

These facts point to the great need for a broadly conceived mental hygiene program of education for our youth. This program should emphasize the importance of a wholesome, harmonious relationship in the home during the formative stage of the development of the child. It should foster education in the ways of democracy and promulgate the ideal of self-abnegation for the welfare of the group, not only during war but in time of peace.

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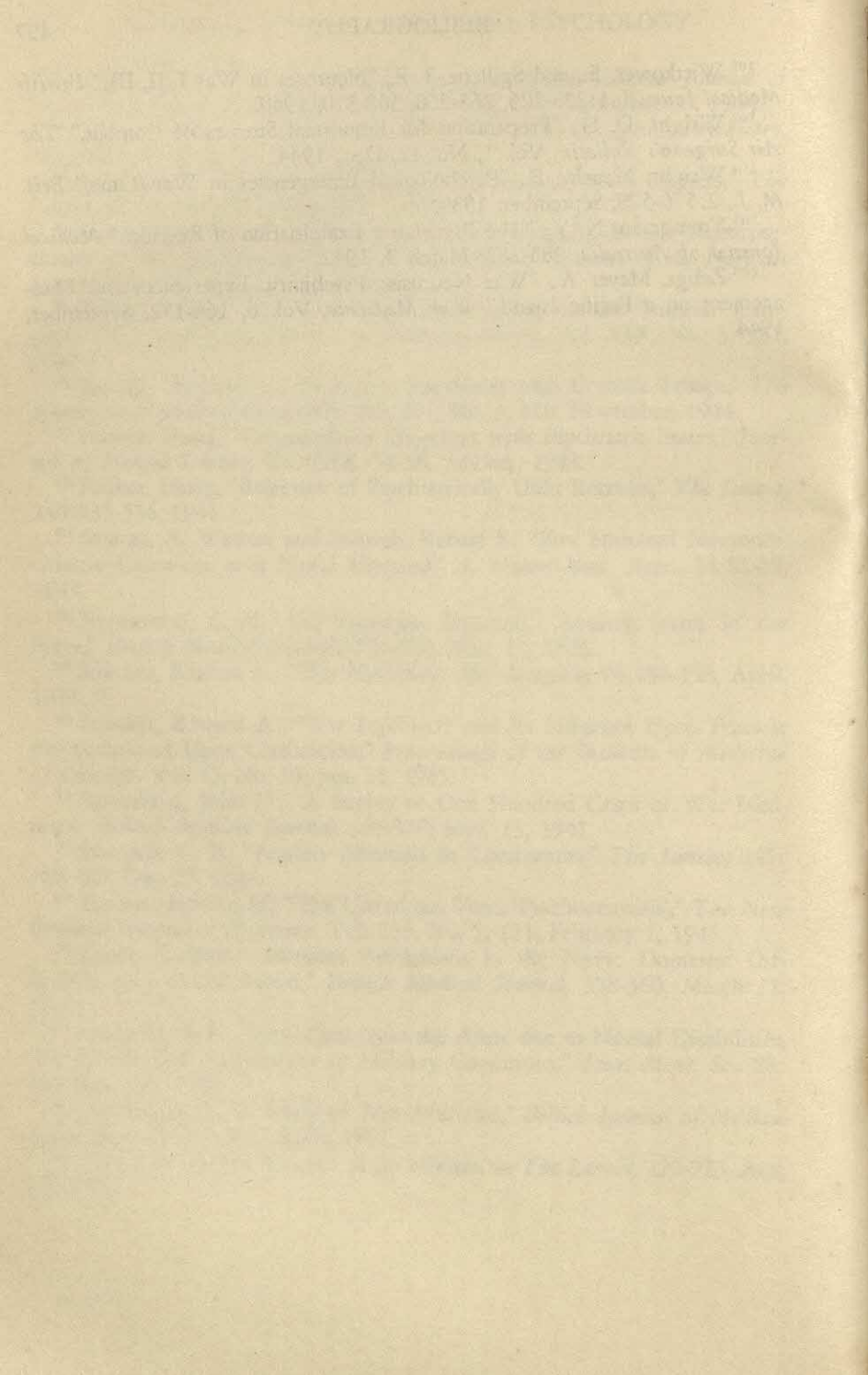
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MANIAC-DEPRESSIVE PSYCHOSES

By

LEO V. TEPLEY, M.D., Psychiatrist

Denver, Colorado

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By

LEO V. TERPIL, M.D., Psychiatrist

Durham, Colorado

Chapter XIV

MANIC-DEPRESSIVE PSYCHOSES

By LEO V. TEPLEY, M.D., Psychiatrist
Denver, Colorado

1. Introduction — Definition

The syndrome of manic-depression is well described in the words of Aaron J. Rosanoff as "A group of constitutional mental disorders in which the disturbances are primarily and mainly in the sphere of the emotions. They are characterized by attacks of excitement or depression, or of mixtures of the elements of both; each attack generally terminates in recovery; but leaves behind a tendency towards recurrence."

It should be emphasized further that the disorder is to a certain extent only, dependent upon faulty cerebral function and is probably due to transitory physio-chemical changes. The brain structure itself is not affected although similar disturbances do occur in organic brain disease.

Emil Kraepelin,¹ the outstanding psychiatrist of the nineteenth century, is credited as being the first to classify and describe this syndrome. In his textbook of 1895, he used the compound title "Manic-Depressive Insanity" instead of "Manic-Depressive Psychoses." However, in the first edition of "Anatomy of Melancholia" published in 1621, Robert Burton² states, "Madness without fever and Melancholy are but one disease, which Jason Pratensis especially labours, and that they differ only secundum majus or minus in quantity alone, the one being

a degree to the other, and both proceeding from the same cause."

"Mania" the Greek word for madness became synonymous with raving madness in contradistinction to being angry or mad at somebody. Mania further implies a morbidly exaggerated, persistent and irrational pre-occupation and craving for certain objects. It is the morbid component which differentiates megalomania from a feeling of self-worth; pyromania from the feeling of enjoyment one derives from watching a glowing fireplace; dipsomania from the pleasure of a social cocktail, etc.

II. A Historio-Anthropologic Aspect of Manic-Depression

Lowell Selling³ believes that the syndrome of manic-depression was current among the cave dwellers. Selling's contention is substantiated by many authoritative treatises on Anthropology and on the history of primitive culture. It is in perfect keeping with clinical psychiatry that the inherently more impressionable savage reacted differently to the taboos of his day than the majority of his jungle or cave co-habitators. The whole environment of primitive man was indeed conducive towards periodic mental and emotional dislocations. Wherever prehistoric man turned, he was faced with beasts of the jungle, ferocious vultures from above and reptiles from below; flooding streams, bursting lava—all ready to destroy him. In the words of Lewis Browne,⁴ "Earth and Sea and Sky were against him; with relentless enmity, with inexplicable hate, they were bent on his destruction. . ."

In addition to the elements of nature, he was confronted with his stronger and more cunning brother-man who by accident stumbled one day onto a better weapon, and being endowed with an innately keener intelligence, acquired an advantage in the struggle for superiority and self-preservation.

Primitive man was saturated, as it were, with an immanent

teleology all his own—each time he was uprooted by either fire, flood or falling rocks, he saw a purposeful meaning of some evil spirit, which carefully planned his destruction. He did not distinguish animate from inanimate objects—to him everything possessed a spirit, usually an evil spirit. He did not know that his shadow was due to the interception of light by his own body, and he was literally in constant fear of his own shadow. Every time he looked into a pool or river, he saw something so weird and awe inspiring—an exact duplicate of him! And that duplicate accompanied him everywhere; “It spread out from himself” as one anthropologist puts it, “then it drew back into itself.” The Tasmanians, the Semoans of the Malay Peninsula, the Bolocudos of Brazil, the Bushmen of South Africa and other savages of similar cultural level refer to the shadow as the soul. At death the shadow leaves the body—it flies away (it is easy to surmise how this phenomenon gave him the idea that death is not the final dissolution of his life). In our modern child literature, we have a beautiful literary atavism, if one may so express one’s self, in the phantasy of Peter Pan, who was stolen by the fairies and taken to live in the tree tops. . . then one night, his shadow was left behind, as he skipped out the window. . . .

Last but not least, primitive man was tormented by fear of dreams and the terror of nightmares. After having devoured his inferior jungle brother when he would recline in his cave and fall into peaceful slumber, he would suddenly be awakened ferociously battling again the very comrade whom he had decapitated but a few hours ago. The more impressionable one, the one who was slightly different in constitution, succumbed to a psychosis—most likely of the manic-depressive type. The primitive Eastern Siberian Shaman, and the magician and the medicine man of later days, were practicing “psychotherapy” on those afflicted with manic-depressive psychoses. Thus it may

be said: psychiatry per se, is the newest of sciences, psychotherapy the oldest.

In his daily ward-rounds of either State Hospitals or private Sanitariums, the psychiatrist sees the manic in perpetual motion—talking, screaming, gesticulating, climbing the windows, adorning or disrobing himself, etc.; the depressive sits bewildered and in frightened agony constantly wrings his hands, emitting only grunts because of his inability to express the fragmentary and horrifying thoughts which torment him. The psychiatrist is a daily witness to anthropology in action.

B. Manic-Depression in Post Anthropologic Days

One need not go back to the caves of prehistoric man to find prevalence of manic-depression. One finds it in the world literature of yester year and even yester month and yesterday. Saul, the first King of Israel, who reigned about 1025 B. C., was suffering from a manic-depressive psychosis. His constant quarrels with Samuel and his imaginary rival, David, who tried to drive away his evil mood of melancholia, by playing the lyre for him, were due to those ugly meditations which often precede a frank depression. Saul, according to "the book of Jashar" (2 Samuel 1-19-27) "was a mighty king, a warrior whose sword returned not empty; swifter than an eagle, stronger than a lion, and whose death was to the Philistines a source of elation." But when he "became greatly distressed by reason of the Archers," the Lion of Judea *implored* his armour-bearer to kill him, "that he might not be slain by the uncircumcised Philistines." Much of Saul's turbulent life and the concomitant emotional upheaval of trying repeatedly to reconcile his wife with the concubines, and one concubine with another, occurred during periods of depression.

The story of Sextus and his slave, which is said to have occurred in the First Century A. D., is psychiatrically very illuminating. Sextus, possessor of many slaves, was particularly

fond of one of them. The Chronicles do not mention his name; I shall therefore refer to him as X. Slave X was most likely an extrovert, perhaps a hypomanic, hence somewhat of a jester to his master. One day Sextus noticed that his favorite slave became unduly active, hypertalkative, and flighty, as we say. He jumped from one subject to another with such rapidity that no one was able to follow him. Without permission from his master, he left his quarters and betook himself to the streets—preaching, talking, screaming and jesting.

Sextus seems to have antedated the maxim, *Cherchez-la-femme* by twenty centuries, for when he was puzzled about something, he turned to his wife for advice. In the words of Lowell Selling, from whose interesting volume "*Men Against Madness*" I quote time and again, "Sextus asked his wife, 'What shall I do with the slave?' "

"There is a doctor down the street, a Greek; his name is Areteus," she said. "All the women in the neighborhood like him. He is jolly, and while nobody could call him handsome, he seems to get remarkable results in treating such cases."

Accordingly, Sextus had Areteus examine his slave. Areteus quickly made the diagnosis, "this is a case of madness, and madness, you know, is the result of someone having incurred the displeasure of a God. Either you or your slave must have offended a God."

Areteus was methodical. He carefully inquired into the relationships of Sextus with all the Gods, beginning with Juno clear down the line of all the deities. Sextus denied ever having offended any, but Areteus knew his psychiatry. "Undoubtedly," he insisted, "Some God has been displeased, most likely Juno. The head is the seat of reason, and Juno is the Goddess of Reason. Your slave's head is surely decayed."

Then, by way of further elaboration, Areteus added, "There are two kinds of madness, mild and severe. Those who have

mild madness are able to go to the market place and are harmless, but the excited kind, like your slave, ought to be locked up. Keep him quiet, no music—warm baths should help. I differ with Asclepiades, who always gives them music and smelling salts. Put him to sleep in a dark room. Take away all noise. He should have lots of rest and good food, but not too much. I am sure he will get better soon.”

This bit of psychiatric history tempts one to substitute the adage, “There is nothing new under the sun” with “not everything in psychiatry is new.” Areteus knew something of prognosis and treatment of the mentally ill.

C. Psychiatry in Literature

Twenty-five hundred years before Kraepelin, Freud, Charcot, Pierre Janet or Adolph Meyer, Plato noticed the frequent relationship between the emotional upheaval following a Fiasco in love and madness, a mental disorder to which we now refer to as a Reactive Depression.

What is loosely spoken of as the mysterious working of the mind, did not escape the all-penetrating eye of literary genius. Great men of letters of all races and of all time, reveal to the psychiatrist mental vistas so intricate and true that he becomes awe stricken at his inability to detect them, in spite of his specialized training. Free association, resurrected by Freud, (Pierre Janet practiced it with considerable clinical success long before the pen-gifted Austrian began to popularize it), the currently popular Rorschach Ink-Blot Test, or any other test, are only helpful in classifying the mentally ill, but they tell us next to nothing of the fine, yet profound, individual variation in the spheres of ideation, emotion and volition.

The late Will Mayo once said that it is fortunate for mankind that medicine is both an Art and a Science. Then he added—“And I hope it always will be.”

With this in view, I shall sub-classify psychiatry, at least for the reader of this chapter, into Inanimate and Animate Psychiatry. Inanimate psychiatry is the scientific textbook psychiatry; animate psychiatry is the human mental and emotional interplay of ideas, actions and reactions as portrayed by the masters of the great literature of the world.

Babinski's "Hysteria" is indeed a monumental work, but its rich content is more fully assimilated mentally by Bjornsen's literary masterpiece, "Beyond our Power." De Maupassant's portrayal of true paranoia in "Mad" surpasses, in my opinion, anything in either contemporary psychology or clinical psychiatry. (Some psychiatrists doubt whether there is such a clinical entity as true paranoia). Similarly, Stendhal's⁵ "La Chartreuse de Parme," written in 1830, is a psychoanalytical masterpiece, which out-shines every description in psychiatric textbooks in either Europe or in the United States since Freud. One of Stendhal's contemporary critics says that when Julien, principal character in another novel, (*Le Rouge et le Noir*) tells Madame de Renal how he feels, "The scene is so precisely recorded that you can hear the boy's heart beat."

It is regrettable that many students of pathological psychology and clinical psychiatry deprive themselves of the aesthetic pleasure of mind beats and their symphonic combinations in the records of the literary masters.

The immortal poem, "Syphilis sive Morbus Gallicus" by Heronymus Fracastor, from which the word "Syphilis" has its origin, stands, to use borrowed words, "well in front of the world's great poems." It gives the reader a remarkably clear clinical picture of general paresis, which results from the occlusion of the terminal portions of the arteries of the brain caused by the *spirochaeta pallida*.

The misanthropy one often sees in the manic-depressive patient is better understood if one is acquainted with Shakes-

peare's "Timon of Athens". In discussing what I call Animate Psychiatry, one cannot omit our own Oliver Wendel Holmes, Dostoevski's⁶ "Brother Karamazoff," Artzibasheff's "Sanin," and most of the works of Proust. There are many others, to be sure, but to mention them all would be going too far afield.

III. Various Forms of Manic-Depression

A. The Non-Dichotic Form

Most textbooks, following Kraepelin, state that there are few cases of manic-depression wherein one of the two components is absent, but the clinical psychiatrist knows that a great many patients simply do not conform to this rule. Many who suffer from mania do not develop a depression and vice versa. This is understandable if one bears in mind that the syndrome often occurs in many unrelated conditions. One patient may develop an acute mania as a result of an infection; another as a result of disfunction of the thyroid gland. There is a very frequent manic state in schizophrenic disorders. And there are many cases of general paresis in which the prominent symptom is that of profound depression.

B. The Acute and Mild Forms

When the patient is at the height of exaltation and hyperactivity (manic) or in the lowest depths of melancholia (depressed), he is relatively a small problem. He is committed to either a State Insane Asylum, or confined to a private institution. It is the great majority of cases, in which the symptoms are not strikingly abnormal, which constitute the greatest problem. The two most troublesome disorders are the so-called mildly depressed and the mildly elated—the hypomanic patient.

The hypomanic in everyday life is usually quick of repartee—a marvelous conversationalist and the life of the party. He is a law unto himself; he never tires of sharing with whom-

ever will listen to his persistent flight of ideas, his schemes, suggestions, and observations, few of which are ever worth listening to. The club members who see him once a week or once a month enjoy him, but his family, who cannot escape from his eternal hyper-activity, suffers greatly. It takes super-human tolerance and understanding to adjust to his tempo.

Not infrequently a chronic hypomanic may, under certain situations or conditions, rather suddenly develop into an acute mania or hypermania. Such is the case of L. W. He is forty years old, married, six feet two inches tall, and of an athletic constitution. He is a minor Union Official. He likes to display his massive biceps, invariably adding, "I didn't get those from praying in Capitalistic Churches. Hard work, hard work, Brother."

At every opportunity he goes into detail about how he came up from the ranks as a coal miner, boasting, "I am a self-made man."

He seems versatile in the doctrines of unionism, Socialism, and other isms. During a mayoralty campaign, he suddenly decided to become a candidate for Mayor. With characteristic hyperactivity and inexhaustible energy, he soon convinced most of the union leaders that he was the man for the job at the City Hall. "If only labor would stick together."

That was in the days when one could rent twelve typewriters and hire twelve stenographers as easily as one could buy a bottle of pop. This is exactly what L. W. did. He cluttered his house with typewriters and stenographers, dictating with a speed which would put Walter Winchell to shame. Often he would dictate to one stenographer one part of his platform, to another something else, and again something different to a third one. Apparently, the hyperactivity was still in keeping with his supposedly normal self. The wife, the prospective cabinet members and other officers of the would-be Mayor would say, "L. W.

is a bit keyed up—but watch him. He'll make it. Such Energy! Whoever suspected that he is such an orator?"

He managed his personal publicity campaign. He distributed thousands of platform leaflets with a photograph of himself on the front page. One day he arranged a meeting in a union hall, challenging the other candidates to debate current municipal issues. None showed up, but the hall was fairly well filled. While addressing his audience in characteristic intonations and gesticulations, he turned to the subject of women suffrage and the role of women in the labor movement. His wife was on the speaker's platform. During the height of his enthusiasm about women and what he was going to do for them after his election, he became charged with amorous urges. He grabbed his wife in his arms, started to demonstrate his affection for her by means other than a mere kiss.

The audience became horror-stricken. Shouts of, "Stop, you crazy fool!" filled the hall. A few spectators declared that, "Something has snapped in L. W.'s head." His wife extricated herself from his arms, but L. W. persisted that he and his ancestors were Americans, and that every American had the sacred right to love his wife as and where he wanted to. Pandemonium ensued. The police soon arrived. After considerable scuffling, he was subdued and taken to the city jail, thence to a hospital for the mentally ill. He recovered in a few weeks as usually happens in the first attack of acute mania.

The early recognition of this mild form is of paramount importance. Generally speaking, the first manifestation of even a mild but true depression is a lack of the former self-confidence. There is an indecision and hesitation to do the things the patient used to do as a matter of course. There is a slight blunting of the keenness of the mind and a lack of the former initiative. The patient suffers from a general psychomotor retardation. "To be or not to be" is transformed into, "To do

or not to do," such and such a thing. The final decision is usually, "not to do." The patient further suffers from a groundless and morbid fear. It is very essential to differentiate pathologic apprehension from normal fear. Freud's classical example that fear of snakes is normal when one is in the African jungle, and pathologic when one dreads their presence under his bedroom rug, is an excellent criterion by which to differentiate the normal from the pathologic.

The following sad illustration of a so-called mild depression is a case in point:

I. C. was an outstanding progressive leader of the United States. He was an intimate of both Woodrow Wilson and the late Franklin D. Roosevelt. The radio carried his voice to millions of homes throughout the United States. He was often bitterly attacked by the chauvinistic and sensational press. Certain columnists were most generous in their invective upon him personally and the socio-economic views he advocated. The cartoonists attached to those newspapers were not to be outdone by their brother scribes. Whenever a particularly vituperative column would appear on the front page, accompanied by a cartoon, I. C. would comment, "This is the price a Democracy must pay for the freedom of its press." Subconsciously, he welcomed such publicity—it stimulated him to greater activity, determination, and enthusiasm. Then he gradually began to lose interest in things. Under one pretext or another, he would refuse to attend certain meetings and would break luncheon engagements. There was a slow decrease in the tempo of all the activities which were, when he was well, an integral part of him.

One time when he was approached by a certain group to appear in behalf of what it considered a certain just cause, I. C. refused. "My appearance in their behalf will do more harm than good. Editor X (he named him) will tear me to pieces on the front page!"

Those who knew him were not in the least impressed with the significance of the lack of self-confidence on the part of the modern Samson who suddenly became frightened of a single Philistine. The indecision, ungrounded fear, and the mild apathy to everything he cherished when he was in good mental health, was not recognized for months. Then all the symptoms became aggravated rather rapidly, and I. C. struck the bottom of depression. He became utterly oblivious to everything he had devotedly worked for during the past forty years of his life. As time passed on, he became more and more distant, first with professional and business associates, then with friends of years standing. Later still, he became utterly oblivious to the affection of his life-long devoted mate, children and grandchildren. He developed a feeling of guilt and a sense of unpardonable sin. He was in morbid fear of being punished because he had "shamefully attacked" his opponents by pen and word. He would spend many hours brooding and castigating himself. After prolonged suffering, he died of a frequent complication of melancholia.

Had those about him recognized that his fear and indecision were entirely out of keeping with his past personality make-up, they would have sought psychiatric aid earlier and might have been instrumental in prolonging a useful life.

IV. Pathologic Alcoholism and Manic-Depression

A great many alcoholics, not the type born to the gutter, but the one with untainted heredity, good environment, and education, college or otherwise, are often victims of manic-depression. As a rule, this type of alcoholic is the likeable extrovert, usually kind, and courteous. He is generous with his purse—the first to grab the check at the restaurant table, irrespective of the number of times he had previously paid for the company of his friends at meal time. He is considerate of almost every one except those who love him—to them he brings untold grief and

anguish by his excessive drinking. He may be either an habitual or a periodic drinker. He is indulging in pathologic imbibition because of a feeling of forlorn hope and imaginary insecurity. He suffers from a pathologic lack of self-confidence—he feels insecure in love, in his social circle, his family. Often he also develops a religious insecurity—faith no longer gives him the former emotional support and comfort.

Every psychiatrist knows instances when the devout Catholic broke his pledge to abstain from drinking in the first tavern on the way from the Priest's rectory. Patients of other faiths have likewise broken their promises to their spiritual advisors. This class of drinkers is running the gauntlet—only the lashes are emotional, spiritual, and mental—hence the blows are more painful and to him, beyond endurance. He feels the need of an anesthetic. The first drink relieves the sting, the second and third exhilarate him; then follows the feeling of well-being. In order to maintain this state of momentary forgetfulness, he takes another drink and yet another, until he reaches the state of alcoholic excitement, followed by confusion and stupor.

The memory of the feeling of euphoria coupled with remorse of "what an ass I made of myself" leads to another alcoholic debauch. An escape pattern is established; with each successive spree the fibres of the pattern become firmer and firmer until he becomes an alcohol addict.

Repeated scolding, shaming, appeals, and threats by wife, lover, parents, and friends invariably fail when the victim is only trying to escape from a mental illness—a pathologic depression. Often such procedure aggravates the situation. The patient whose underlying indulgence in alcohol is due to a depression is frequently a most difficult one even to the trained psychiatrist. Then again as Dr. Glaister H. Ashley puts it "the patient makes a sudden recovery from his alcoholism when the depression is over and many reasons are given for his cure,

though the alcoholism was purely a symptom of the mental depression."

V. "Sham-Depression"

The psychiatrist is often confronted with the problem of diagnosing a disguised sympathy craving which is masked by a depression. This type of patient is a source of great worry to his family. The experienced observer will easily detect the cloak of depression which is merely an attention device. The following case is typical:

H. C. is four years younger than his seventy-year old wife. She had a paralytic stroke nine months ago, and became a helpless invalid. She is unable to utter a single word or move any part of either of her right extremities. Mr. H. C. is Jewish and has the typical attachment for wife and children characteristic of that race. After I had examined Mrs. C., I told her husband that nothing could be done for his wife except to make her comfortable by careful nursing. When I further told him that in the present state of our knowledge, there was no hope for her ever being able to either walk or talk again, he became excited and cried loudly—over and over again—"I can't stand it—I can't stand it any more—I can't take it any more. It's the exhaust pipe for me!"

But in the very next breath he said, "I'm going away for the holidays (a month hence). After that, maybe I'm going into a little business." Victor Hugo must have seen a Mr. H. C. when he remarked, "Melancholy is the pleasure of being sad."

Classification and General Symptomatology

A. Classification

The manic-depressive syndrome is usually divided into a number of entities: the mania form into circulatory mania, hypomania, acute mania, hypermania, delirious mania, chronic

mania, etc. The depressive form is separated into mild depression, chronic depression, maniacal stupor, agitated depression, reactive depression, and a number of others. Only symptoms which serve as a warning of an approaching disaster—the flash of the yellow before the oncoming red—so to speak, will be discussed.

B. General Symptomatology

Dr. C. S. Bluemel, author of "The Troubled Mind" and a recent publication, "War, Politics, and Insanity," once remarked, "There are as many different psychoses as there are psychotic patients." There is a great deal of truth to this seeming aphorism. Basically, it is true that many patients can be roughly differentiated by one psychiatric label or another, but their outstanding characteristic is that each patient is a law unto himself.

Psychosomatic medicine, the remarkable new science, as one non-psychiatric writer refers to it (it is as old as the art of healing itself), stresses the importance of treating each patient as a distinct personality all his own. It is very important to understand the psyche better if the physician is to help the patient in his somatic distress which is greatly affected by emotional oscillations. Even in the purely somatic field there are no two bodily aches exactly alike. Pain—the cry of alarm that there is something awry within the human constitution is manifested by the interplay of many mental and emotional attributes. The innate difference in the threshold of consciousness and subconsciousness is responsible for the great variation in the patient's reaction to whatever is wrong with him. This applies infinitely more to the actions, reactions, as well as to the method which each mentally and emotionally disturbed individual employs as an escape from the underlying disturbing factor. The definition of the manic-depressive syndrome, as given at the very outset, should be helpful in understanding the

complex symptomatology of this entity.

To clarify the subject somewhat more I shall quote again from Burton's "Anatomy of Melancholia."² Sir William Osler has spoken of it as "a great medical treatise, orderly in arrangement, serious in purpose." "Melancholia," says Burton, "is either in disposition or habit. In disposition, it is that transitory melancholia which goes and comes upon every small occasion of sorrow, sickness, trouble, fear, grief, passion, or perturbation of the mind, discontent, any manner of care or thought which causes anguish, dullness, heaviness, and vexation of spirit. . . . Mania is far more violent than melancholy—the patient is full of anger and clamor, horrible looks, actions, gestures, troubling the patient with far greater vehemency both of body and mind, without all fear and sorrow, with such impetuous force and boldness that sometimes three or four men cannot hold him." One can now see how hard it is to improve upon this three-hundred and twenty-seven year old description. The individual case histories which I cite will, I hope, serve as an alert that certain mental clouds, even mild, often are early indications of a manic-depressive syndrome.

VII. Heredity and Manic-Depression

The claim of some clinicians that manic-depression is the "most hereditary" of the psychoses, is not borne out by either uniform clinical experience or statistical data. It certainly is not hereditary in accordance with the Mendelian Law. Research in the field of human genetics has as yet, according to Rudin "failed to prove the existence of either a dominant character, a recessive character, or a simple sex-linked one which begets this clinical entity."

Even in identical twins, the disorder does not occur with absolute regularity. Those who have studied this subject in monozygotic twins, give the varying figure in which one twin

only is affected, as 51 and 62 respectively.

Human hereditary (the sum total of all intrinsic factors) is most baffling. It is full of pitfalls in the normal and is appallingly more so when one considers the abnormal. The problem of the human constitution in the words of David Abrahamsen⁷ and in the opinion of many others, "remains thus far an enigma." All that can safely be said in the present state of our knowledge is that human behaviour in sickness and in health, in poverty or wealth, is best explained in terms that ingrained human tendencies (heredity) are influenced, or under somewhat certain conditions may become modified by environmental factors.

As an illustration, I shall briefly cite a few characteristics of Professor R., one of America's outstanding scientists and a president of a great university. He springs from a poor family of European stock. He is an aristocrat of mind and a democrat of character. At the pre-adolescent age his income would become regularly enlarged by several nickels on every Sabbath Day when he would light the ovens for the Children of Israel in the Ghetto. His child-mind became greatly impressed with their family atmosphere, religious ardor, and the strange unintelligible symbolism. In the neighborhood of the Jewish Ghetto, he also came in contact with many other socially and economically underprivileged children and adults of the minorities. He developed a liking for them (such experience is most likely responsible for the psychologic maxim: To hate one is not to know him or not to understand him). Many students who are or think they are being discriminated against seek him out. They do it more because of a social chemotaxis as it were, than even to get the benefit of his wise counselling. R. is always happy in their midst. Occasionally I have seen him in action amongst such groups and I always wondered—where does heredity start and environment end? What makes R. what he is?

In summarizing the heredity of the Manic-Depressive psy-

chooses one must say, that they are decidedly not typical heredity diseases like amaurotic family idiocy, Huntington's Chorea, Schilder's Disease and others. In fact, the more one studies this so-called "most heredity" disease, the more he is inclined to think that it is the most uninherited psychosis.

VIII. Etiology

The cause may well be stated in two syllables—unknown. Certainly the substitution of the two syllables with the two words, *mostly unknown* will cover the field. There is often a precipitating factor or factors. The daily wear and tear of the body physiology frequently brings on an attack of manic-depression. It many times follows pregnancy, acute infections, and childbirth. The wear and tear element is further supported by the fact that the greatest number of these catastrophies occur between the ages of 20 and 40—the period of greatest expenditure of human energy. Sex and its intricacies in some way, are probably related to the development of this condition. In spite of the fact that the environment under which 20th Century women live is better than that of men—the ratio of women affected with manic-depression to that of men, is two to one.

Psychogenic factors play a great part. Disappointment in love or in a devoted friend, loss by death of a beloved one, parent or mate, severe financial reverses, the uprooting incident to selling a home to which one had an attachment other than the mere security of having a roof over the head, often bring about a reactive depression. Retirement from business or profession when one is still mentally keen, even though not as vigorous as formerly, often results in a manic-depression. In many instances, patients become chronic invalids.

IX. Prevalence

There are no exact figures as to the number affected with one or the other form of this mental disorder. Roughly speaking, it constitutes about one-eighth of the total population within state institutions. The fact that these attacks are as a rule transitory, and the unfortunate further fact that it still is considered a stigma to have one committed to state hospitals, makes it difficult to obtain numerical data. The so-called mild cases are usually taken care of at home or in private institutions. When one takes all these factors into consideration, the total number of the manic-depressive group probably comprises one-fourth and one-fifth of all the mentally ill.

X. Treatment

The details of special treatment such as shock induced by either physical, mechanical or chemical reagents, which only the specialist is capable of carrying out will be omitted. I shall only mention treatment in a general way and shall emphasize a few practical suggestions which will be helpful to the non-specialist. One should always be kind and yet firm with the patient. One should never lie to him or whisper in his presence. The patient invariably injects the wrong meaning into such a procedure, and he may become more excited or depressed. It is wrong to take him to a hospital under the pretext that he is going to take a pleasure ride. Patients who threaten suicide or talk of suicide and the futility of their lives should not be taken lightly. Briefly stated, the psychologic mechanism of one who *honestly* contemplates self-destruction, can be summarized somewhat as follows: The average *normal* individual fully realized that in destroying his own life, he merely substitutes "sui" for "homo". He is fully aware that he is contemplating a horrible deed. He may think of it as the unpardonable sin, premeditated, cold-blooded murder, the act of a despicable

coward, etc. Again he may be haunted by the thought of inflicting much pain and sorrow on at least a few who love him and need him. The talk about suicide is the sick individual's silent appeal and plea for forgiveness to those he loves. It is his inaudible prayer: Believe me my dear ones, I do not want to hurt you—I am not as inhuman as my act seems, but to me life is futile. He becomes imbued with the thought when life no longer is a pleasure—death becomes a duty. This is also a rationalization process and an attempt to justify himself in his own eyes. There are other subtle psychologic mechanism particularly in an unstable individual. The superego does not believe in pragmatism. He will not only cut the ego's nose to spite his face, but he will ruthlessly destroy him and at times in the most horrible manner. Avenge and revenge are often contributing factors. The layman's attitude that one's talk about suicide proves that he is a coward and is only bluffing, is not in keeping with clinical experience, although as was mentioned earlier, during certain phases of the disease, indecision and even pathologic indecision, abulia, as it is called, is a symptom of manic-depression. Sarcasm and ridicule when sown upon a morbidly conditioned human soil, may be the precipitating factor and lead to disaster. The tragedy of Private B., is another case in point.

Private B. was a patient in a Government hospital for tuberculosis. He was mildly depressed. Each time he, among other patients, would come to Miss S., the jovial, pretty, and much admired nurse on the hospital ward for some medicine or rubbing alcohol, she would try to "kid him out" of this depression by tenderly mocking him, "Why so down in the mouth? The doctors say it takes only 11 muscles to laugh with and 19 to frown with?" The soldier took these affectionate reproaches as meaning that the nurse was poking fun at him. One evening before coming for his nightly medicine, he had a slight pulmonary hemorrhage.

This time he did not give the nurse a chance to, as he thought, rebuke him—he greeted her with the question, “What would you do if you had a hemorrhage, Miss S.?”

Pouring the medicine into the glass without looking up, she replied, “I would jump out of the window.” The bystanding soldiers laughed good naturedly. Private B. obeyed orders in “true soldierly fashion.” He jumped out of the third story window the minute he reached it and died a few hours later of a fractured skull. Miss S. developed a reactive depression! It lasted for months. The haunting feeling of guilt was so intense that it took utmost precautions to prevent her from paying with her own life for the death of her patient.

The following case is also deemed worthy of recording:

Tall, slender, white-skinned, brown-eyed, red-haired, M. G., is 21. She had always had a feeling, and not entirely without cause, that her sisters at large were hypercritical of her and “picked on her.” Many indeed did. They often would within hearing distance, point out every little blemish in her complexion. Some would say she was “kinda” cute, others would “not even call her good looking,” a few would refer to her as the “gorgeous red.”

“Ever since I can remember,” she’d complain indignantly, “they’d call me ‘Red and Red-Head’.” There was one old man in our town; he must have been 60, if he was a day—he always managed to come near me when the sun would shine on my hair and pet me on the top of the head. I could have kicked him on the shins.” She was morbidly sensitive to what she called being molested and dissected alive by everybody. She was even resentful of her mother’s calling her “my darling Cameo-Face.”

M. G. was an emotional type of girl, given to day dreams and uncritical thinking. When she was alone in her room she would unbeknown to her family, spend a good deal of time in free drawing—depicting with pencil some of her innermost

thoughts. (She had considerable innate ability in the art of drawing). She was unconsciously conscious of her beauty. Her three year older sister was jealous of her. M. G. treated her admirers coldly and indifferently. One day she desperately in love, but "the only man whom she ever loved," rejected her coldly. She brooded, grieved, became preoccupied and for hours would sit and stare into space. Her jealous sister would often say: "Don't disturb M. now, these are her hours of licking her heart sores." At one time M. exclaimed, "I'll end it all—what have I to live for?" Her sister made fun of her and told her that she despised heartbroken beauties who threatened to commit suicide. Thirty minutes after this rebuke, M. was found on the floor deeply unconscious.

When I arrived, she was cyanotic; I could not feel her pulse, the stethoscope revealed barely audible heart sounds. Artificial respiration and other stimulants kept her breathing until an ambulance arrived with oxygen equipment. Fortunately she recovered. She is now a well stabilized person and the mother of two fine children. A young life was almost prematurely destroyed by a sinister combination of lack of understanding and kindness on the part of a member of the family.

XI. The Future

In discussing one of the oldest mental afflictions, one should note, parenthetically at least, that there is no cause to fear that the wear and tear of modern society's civilization, its culture and dizzy technological progress, will lead to an appalling increase in mental disorders. This optimistic view is based upon known facts of the history of man. The trials and tribulations of modern man pale into insignificance as compared not only with those of our primitive ancestors, but with the hardships of our great, great-grandparents. In spite of all the harsh and oppressive obstacles, man survived. And man will!

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Chapter XV

MANIA-DEPRESSION
OF FAMOUS MEN

By

LEO V. TEPLEY, M.D., Psychiatrist
Denver, Colorado

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(Ludwig Van Beethoven, Leo Nikolaevich Tolstoy, Peter Ilich Tchaikovsky and Charles Dickens)

By LEO V. TEPLEY, M.D., Psychiatrist
Denver, Colorado

I. Introduction

The psychiatrist in his daily contacts with patients inside and outside the walls of the psychiatric hospital is puzzled with a certain human deviation from the normal pattern of activity — the syndrome of mania-depression. This is probably the oldest mental affliction. In the previous chapter it was briefly mentioned that mania-depression most likely manifested itself in prehistoric man; those endowed with a higher mental and emotional potential were the first victims of this disorder. This malady affected Saul, King of Israel, Cato ("The Younger") of Rome, and the four geniuses discussed in this chapter.

It seems that in genius the very mechanism of perception, ideation, emotion and volition are particularly governed by intrinsic laws which as yet defy the neuro-anatomist, neuro-physiologist, psychologist, and clinical psychiatrist alike. The clinical psychiatrist becomes even more bewildered when he tries to understand genius in sickness and in health. Why some like these four described in the following pages conquered the urge for self-destruction, and others failed — to mention only Robert Schumann of yesterday, and Wynant, ambassador to the

Court of St. James, and James Forrestal, first U. S. Secretary of Defense, of the present — is the puzzle of puzzles. In discussing mania-depression, one cannot get away from the thought of our own Abraham Lincoln, who — fortunately for mankind and more so for Americans — mastered the depression and achieved the goal destiny chose for him.

II. Ludwig Van Beethoven

A. Few Know the Man, Beethoven

One may not agree with George Santayana, well known philosopher, who once remarked that God created the world in order that the Ninth Symphony might be written; but everyone whose ear is attuned to music agrees that Beethoven is the Shakespeare of music, and Shakespeare, according to Taine, is a great creator. Everyone knows that Beethoven is one of the greatest composers of all time, but few know anything of Beethoven the man. The meager knowledge that is available about him consists of distorted glimpses of a genius of first rank who was suffering from a mental disorder: mania-depression.

B. An Unattractive Figure, Sublime and Melancholic

Beethoven, the man, presents a typical example of how a tainted heredity plus a bad environment may thwart the life of even the greatest of geniuses. From early childhood he suffered the physical pangs of frequent merciless beatings inflicted by a half-crazed, drunken father, and the spiritual anguish of anxiety, loneliness, and insecurity. Everything in his environment was conducive to the development of a chronic manic-depressive psychosis; wherever he turned, he was faced with disturbing situations which were instantly converted in his mind into oppressing and depressing situations. Try as he might to stretch his body, it would never quite reach the height of 5'5". Accustomed habitually to straining his extremely myopic eyes in

order to see things clearly, he became even more conscious of his un-aesthetic exterior. His hydrocephalic head, resting upon powerful shoulders, merged with his equally powerful biceps and triceps. At first sight, at least, he was almost awe-inspiring. Indeed, from his shoulders down, Ludwig van Beethoven would have been completely at home in an arena of pugilists. His stubborn, strong jaws according to Romain Rolland ¹ "that could grind nuts" accentuated his pocked face. It was no mere accident that he frequently let his beard grow in order to cover a good portion of his face. His habit of splashing ice-cold water over it, as well as that of taking prolonged ice-cold baths, was not the best treatment for an already marred constitution.

People in general are much more inclined to glance at things than really to see them, and at a mere glance, Beethoven indeed appeared an ugly creature. It was given to but a few to see a divine spark in his eyes which illuminated the noble lines of his suffering face, and a look of sublimity on his countenance when he was creating. . . His countenance would light up with an inner radiance when he improvised, or after musical ideas had crystallized into the harmonies and melodies which still quicken the hearts of millions; but most of the time Beethoven looked mournfully at the world with the sad, agitatedly depressed, lack-luster eyes of chronic melancholia.

C. Description of His Own Melancholy

Severe self-depreciation, suicidal ideas, and vague psychosomatic complaints are frequent symptoms of manic-depression, and Beethoven suffered from all of them. To use his own words, "Melancholy — that for me is an evil almost as great as illness itself. . . Happiness is not intended for me, or rather, I am not intended for happiness. . . I have been put into the world not to enjoy a pleasant life. . . Art alone has detained me from taking my life. I emptied the cup of bitter suffering; it is but

transformed into the beauty in my soul. . . patience and work I owe to myself and to the Almighty. . . I must write my music."² And again, in a milder tone, he says, "I am not very satisfied with the works I have so far written. From today I mean to open up a new chapter."³ According to Romain Rolland, author of the above mentioned book *Beethoven the Creator*, one of Beethoven's piano sonata slow movements (Opus 10, No. 3) describes, in his own words, "the state of mind of a melancholic." A string quartet slow movement (Opus 18) he entitled *La Malinconia*. This lapsus linguae bespeaks much of his mental and emotional turmoil.

D. His Manic-Depressive Psychosis Explains Much

Of all the enigmas, genius is the greatest, Thomas Edison's definition that "genius is one per cent inspiration and ninety-nine percent perspiration" notwithstanding. It takes genius to fuse one percent of inspiration with ninety-nine of perspiration and create an incandescent lamp or an Othello, or to convert a hallucinatory spark into a Ninth Symphony. Beethoven, the genius, and his so-called abnormal conduct are best understood if we realize that he was a victim of a manic-depressive psychosis. In trying to explain his complex personality by this approach, I follow somewhat the following lines of reasoning.

Astrology was not the final explanation of the nature and movement of the celestial bodies; it was as far from modern scientific astronomy as this planet is from Jupiter. But any explanation of things, even though faulty, is better than no explanation at all. The first step on the ladder to scientific astronomy was made when man became curious about things in the cosmos, beyond his reach. As long as man did not even attempt to explain things, he remained immersed in darkness. Darwin's account of the creation of the universe seems more reasonable, at least to some, than that of Moses, even though

Darwin does not explain everything. The nuclear theory is preferable to the molecular one, and the nuclear scientist becomes awe-stricken at the paradox that the more he knows, the less he knows.

The best interpretation of the mundane behavior of the creator of the Ninth Symphony is, to repeat, that he was suffering from a mental illness: mania-depression.

E. A Splendid Man When Not Manic or Depressed

When Beethoven was not in a state of either mania, hypomania, or profound depression, he was a generous, kind, and most charming individual. Even in some of his verbal storms, to use the words of Rolland, "he was a lovely human being." Beethoven's education was indeed not a formal one — it consisted of scarcely more than the three R's. Parenthetically one may ask, did he, the genius, need more? He loved and *knew* the works of Homer, Plutarch, and Shakespeare. He developed — "created" might be a better word — a religion all his own. According to one trustworthy biographer, he sincerely believed in the brotherhood of man in the truest sense of the word, and he believed in democracy. He was a great admirer of Napoleon Bonaparte, because he considered him the great emancipator of mankind from the chains of economic slavery and superstition. It was to Napoleon that he dedicated *Eroica*. The great "crank" has left these seven words in writing: "Socrates and Jesus have been my models."⁴

The immortal Goethe, who could see perhaps only a millimeter or two less than Shakespeare — hence, he could see almost everything there is to be seen in the human being, even in genius — said, "Beethoven is an entirely untamed personality, but the sincerest artist I ever saw."⁵ It should be remembered that Goethe knew Mozart and Haydn as well.

F. His So-called Ill-breeding Was Only Depression

The impression that Goethe made on the genius of the "wordless language," as Deems Taylor alludes to music, is characteristic of Beethoven's understanding of things other than music. "Goethe," he said, "is the most precious jewel of our nation. The appearance of such a man is, in my opinion, the greatest thing that can happen in an epoch."⁶ (But one time when Beethoven and Goethe were walking on the streets of Teplitz, they encountered a parade of the whole royal family — the Empress of Austria and all the arch-dukes. Goethe instantly stepped aside, removed his hat, and stood at attention, as it were, as long as the royal family was in procession; but the creator of the *Sonata Pathétique* continued to walk, hat on, head down, arms crossed, completely oblivious to everything and everybody about him, including Goethe. Beethoven frequently wandered aimlessly, preoccupied to such a degree that on many occasions he obstructed traffic and bumped into people and various objects. Once he was arrested for vagrancy.

Beethoven failed to pay homage to the royal procession because he was in a state of profound mental depression. He was at that hour thinking black, feeling black, hence acting black! Yet many biographers cite this as an example of his ill-breeding, ill temper, rudeness, and similar adjectives. A man capable of such supposedly normal rudeness could never have written "*Seid umschlungen, Millionem! Diesen Kuss der ganzen Welt* (Be embraced in love, ye millions! Here is a kiss for all the world.)."⁷

The account of one biographer that Beethoven and Goethe were walking arm in arm when they met the imperial family, and that Beethoven indulged in a dialogue on the subject of genius versus royalty and nobility, is not borne out by many critical and objective students of his life. It is indeed not in

psychologic keeping with the nature of Ludwig van Beethoven.

G. Illustration of His Remorse

Pathologic remorse and self-accusation occur frequently in manic-depressive disorders. My patient, Mrs. T., a butcher's wife from a Nebraska town of 1,500, wept incessantly; she was profoundly depressed and remorseful, because years previously she had borrowed a cup of sugar from her neighbor and had failed to return it. "Doctor, please, please," she would beg time and again, "Tell her that I am a thief and a liar. I am horrible and deserve this punishment." And now let us present a parallel example from the life of the genius in whom every millimeter of his ten billion nerve fibers was attuned to the highest pitch. Listen to his remorse as he speaks to his friend, Dr. Wegeler, with whose wife, Elenora, Beethoven was very much in love before she married the doctor: "Dearest! Best! In what odious light you have exhibited me to myself. I acknowledge it. I do not deserve your friendship. . . but thank heaven, it was no intentional or deliberate malice which induced me to act as I did toward you. It was my inexcusable thoughtlessness which prevented me from seeing the matter in its true light. . . ah, Wegeler, do not reject this hand of reconciliation. I am coming to throw myself into your arms. . . Pray, give yourself back to me, your peneitent, loving and neverforgetting friend."⁸

H. His Sense of Humor

In the words of Rolland, Beethoven was too much of everything. Indeed, he *was* much too much of everything. When himself, he frequently exhibited a keen sense of humor. When he was told that a certain critic had said of one of his symphonies, "If Beethoven continues this sort of trash, our orchestras will degenerate into instrumental debating societies," he smilingly replied, "A few fly-bites cannot stop a spirited horse."⁹ And

when on a certain New Year's Day, as he was sitting down to dinner, a letter came from his brother, Johann (with whom he did not get along very well), enclosing a calling card on which was conspicuously printed, "Johann van Beethoven, *Gutsbeitzer* (land-owner)," Beethoven took the card and wrote on the back of it, "Ludwig van Beethoven, *Hirnsbeitzer* (brain owner)." ¹⁰ In this connection, one may cite as a point in counterpoint, so to speak, one allusion he good-naturedly made to standards in music: "The rules forbid this succession of chords; very well, I allow it." ¹¹

I. His Outbursts of Temper

Beethoven might have, or he might not have, tried to emulate in the Ninth Symphony all of what Goethe did in *Faust*. But his outbursts of temper — his compulsive acts such as tearing to pieces the music sheets of his pupils, even those of the ladies of the aristocracy, and then trampling his feet over them — were psychotic manifestations of a mind and soul which were running the gauntlet. But the lashers and lashes were invisible, and they struck crueler blows than the servants of the Inquisition.

In a mind of the caliber of Beethoven's, these tantrums are the psychic acrobatics of our anthropologic inheritance. Anthropology in the older usage (which is still new) included in its science the mutual relationship of the body and mind. These remarks deal primarily with Beethoven, the anthroposman, although he obviously was not as Romain Rolland thinks of him: God and man!

One afternoon Beethoven came to the home of his benefactor and genuine admirer, Prince Lichnowsky, and found there some of Napoleon's soldiers. Like lightning, the sight of them threw him out of mental gear. Prince Lichnowsky asked him to play for the officers. Beethoven refused! When the host jokingly insisted, "Unless you play, we shall retain you in the castle as a

prisoner of war," a storm of associations of bitterness, pain, and disillusionment erupted in his mind; the volcanic vent was touched off by the memory that the one whom he believed would bring freedom and liberty to the world had become metamorphosed into a tyrant. He rushed out of the castle, and, as he encountered the bust of the prince, smashed it to pieces. Later he wrote, "Prince! What you are, you are by accident of birth; what I am, I am of myself. There are and there will be thousands of princes. There is only one Beethoven."¹³ In inaudible language, he must have said, "Aristocracy of mind can never creep; it keeps on towering and towering heavenward." He proved this by every one of his compositions from the first set of variations and the three sonatas of 1782 until the Ninth Symphony in 1824.

To Beethoven it was sacrilege to play before a group of sword-wielders, even if those swords were wielded by order of Napoleon. Beethoven's conduct at that particular moment (the Lichnowsky incident) did not reflect the workings of one who is ill-bred and a crank. Cranks, too, must eat, and a great portion of Beethoven's food came from a pension furnished by Prince Lichnowsky. The psychiatrist sees only too often these so-called outbursts of ill temper which are, in reality, manifestations of a manic-depressive psychosis.

J. Falling In and Out of Love

Beethoven minus the malady was constantly falling in love with someone. Once he even proposed to the beautiful singer of the day, Magdalena Willman. When, years afterward, she was asked why she rejected the author of the *Appassionata* Sonata, she smilingly replied, "Because he was so ugly and half-crazy."¹²

Beethoven minus his illness is a normal man, at least in the

sense that he is a polygamist — being married to his legal wife, music, yet constantly falling in and out of love. For sixteen “normal” days he gave Josephine (Pepi) Brunsvik, then 18 years old, piano lessons. Says Pepi,¹³ “Instead of staying an hour after midday, he would stay four or five. He never tired of lifting and bending my fingers, which I had a habit of holding straight and stiff when lifting them. The noble being must have been quite satisfied with me, for he did not fail us once during sixteen days.”¹⁴ (The psychoanalyst would interpret differently this symbolic action — the teacher straightening out his pupil’s stiff fingers for hours and hours.) He would cease “teaching” only when Pepi’s grumbling stomach would serenade: Herr Beethoven, pray, I am so hungry!

After each fiasco in love, Beethoven rationalized as would any normal disappointed lover: “If I had been willing thus to sacrifice my vital force, what would have remained for the nobler, the better thing?”¹⁵ When Giulietta Guicciardi, the “*Damigella Contessa*” to whom he dedicated the Moonlight Sonata, exchanged him — after a short period of flirtation — for Count Gallenberg, Beethoven, the disappointed normal lover, rationalized: “But, after all, she loved me more than she ever did him, only. . .!”¹⁶ Thus the ego of the lover, even though badly hurt, was not mortally wounded.

K. His Hypo-Mania

When he is hypo-manic, he says, “My youth — yes, I feel it — is just beginning . . . for some time now my bodily strength has been increasing, also my power of mind. Each day I get nearer the goal of which I am conscious but cannot describe . . . oh, it is so beautiful to live life a thousand times.”¹⁷ But when the hypo-manic merges into the frankly manic phase, Beethoven shouts, “*Kraft uber alles!*” (Force above all else). “The primary condition of the free man is strength.”¹⁸ Of those who lack

the strength which he worships in his maniacal outbursts, he says, "I rate him and those of his species only according to what they bring me; I regard them purely and simply as instruments on which I play when I please."¹⁹

This man (the depressed side of Beethoven's mind) whom Romain Rolland describes as "rich in scorn for the feeble, the ignorant, the common, and the aristocracy alike, and even for the good souls who love and admire him," says to Czerny, "And yet I had some talent for music."²⁰

L. His Tyrannical and Drinking Father

In bringing this to a close, a few other environmental factors affecting the man whom Romain Rolland justly deifies as "Beethoven the Creator," should be mentioned. Another child in the Beethoven family, also named Ludwig, died two years before the composer was born. His alcoholic father was envious of the money, the child prodigy, Mozart, had brought in from concert playing, and in his greed he would shame Ludwig that, though he was older than Mozart had been, he made no money at all. On one occasion his father claimed that Ludwig was older than he actually was by showing him the birth certificate of his older brother, also named Ludwig. The child was not overly impressed, because he was already cognizant of the deceased brother's previous existence. Ludwig's father would often lock Beethoven in a clothes closet with his violin when he was but seven years old and exhort him to practice, for the sole purpose of procuring money for more drink for himself. At nineteen Beethoven was compelled to become his deteriorated father's guardian. The fact that Beethoven was morbidly conscious of his lowly genealogy — one grandparent having been a pathologic drinker and another perhaps a psychotic — constantly robbed him of the mental peace that is utterly necessary between

the periods of active creation of music.

To discuss his deafness would be to dilate on the obvious. One phrase will suffice to emphasize how Beethoven the Creator felt about it: "Know," he said in a letter to his intimate friend, Amenda, "That the noblest part of me, my hearing, has become very bad."²¹

Wherever he looked, whether at his heredity or his immediate environment, his shabby, ill-fitting clothes or his unkempt bachelor's quarters, pathologic depression was the inevitable result. A person of his great sensitivity could do only one of two things—destroy himself or immortalize himself. Fortunately for mankind, Beethoven chose the latter.

III. Leo Nikolaevich Tolstoy

A. Tolstoy, Born an Aristocrat

Count Leo Tolstoy *had* much too much of everything a man could have, but he *was* not too much of everything as Ludwig van Beethoven was. Beethoven was born in the slum district of Bonn; Tolstoy was born in a forty-two room mansion, Ysnaya Polyana, in the province of Tula. There were quarters for private tutors, the private Tolstoy orchestra, individual headquarters for various dignitaries and special guests. The Tolstoy villa was adorned with seven lakes, and the grounds of this country seat were bedecked with flower beds of indescribable beauty. Beethoven's mother was a cook; Tolstoy's a princess. Beethoven's family were lowly immigrants from Belgium; the Tolstoy family had the title of Count bestowed upon them by Peter the Great. And unlike Beethoven's forbears, Tolstoy's ancestors belonged to a mental and titled aristocracy.

B. Tolstoy and Beethoven Had Much in Common

But the two had in common the greatest of enigmas: Genius.

Both were given to depressive moods, so-called tantrums, excesses, and pathologic remorse. Both suffered from chronic manic-depression. Both were equally misunderstood by their contemporaries, and particularly by their teachers. Albrechtsberger, who tried to teach Beethoven composition, said, "Beethoven never has learned anything and will never learn anything. As a composer, he is hopeless."²² Tolstoy's private tutor, Polonsky, said, "Leo neither wanted to learn anything, nor was he capable of learning anything."²³

Beethoven's letter to Prince Lichnowsky may be paralleled to the one Tolstoy wrote the Czar. The police suspected him of unorthodox ideas regarding the then prevalent concept of the holy trinity: God, the Czar, and the Church. While he was away on a hunting trip, gendarmes searched his library for literature prohibited by the censor; they read his diary, and Tolstoy was told about it. He instantly addressed a letter to the Czar: "Your Majesty: Your officers searched my house when I was away on a hunting trip. They read my diary. Hence I shall always carry a loaded revolver, and I shall shoot any of them on sight."²⁴

Tolstoy did not get along any better with his great literary contemporaries than Beethoven did with his fellow composers. When Haydn, who taught him harmony for a time, disappointedly remarked that Beethoven should have signed his name to a certain composition as "Pupil of Haydn," Beethoven retorted, "I am not his pupil. I never learned anything from him."²⁵ Beethoven would at times dress up in rich and very conspicuous clothes, and parade in the ballrooms of the Vienna aristocracy. He even took dancing lessons, trying to make an "impression" on the titled ladies, but dancing stimulated neither the dancing centers of his brain nor the motor nerves of his feet. Tolstoy, who was born in a cultural atmosphere, soon, too, became bored with such diversion. He felt awkward, acted ill-mannered, and antagonized the other guests by his artificial presence in their midst.

Beethoven and Tolstoy repeatedly suffered from disappointment in love. One of Tolstoy's biographers says, "Tolstoy's other bad habit is falling in love too many times, at least for a day or two, with every good-looking woman he meets."²⁶ In 1851 when in the Caucasus, where he had enlisted as a yunker (a gentleman volunteer), he, as Nazaroff puts it, "under the influence of the sun's rays" in that beautiful country, proposed to the illiterate Zoya, daughter of Erloshka, the Cossack. He begged her to marry him. With all his capacity for depicting emotion, he described with innate artistic honesty how much she meant to him. When on one occasion the declaration of his devotion and feeling for her reached the highest point, and he exclaimed, "I can't go on without you any longer," the illiterate peasant's daughter, to whom his animation undoubtedly seemed mere nonsense, looked at him intently, and then said, "You have not the courage, you bielorutshka (meaning you white-handed one, or good-for-nothing one)!"²⁷ Similarly, Magdalena William refused Beethoven's proposal of marriage, "because he was half-crazy."

C. Tolstoy's Christian Faith

Like Beethoven, Tolstoy created a faith all his own. During long periods of depression, Tolstoy sought solace in religion, but the Greek Orthodox Church, with its rituals, fasts, and incantations, which he looked upon as mere paganism, did not satisfy his spiritual needs. He renounced the Church long before it excommunicated him officially. Beethoven's models were Socrates and Christ, in the order mentioned; Tolstoy's were Christ and the Apostles. The author of *War and Peace*, too, developed a religion all his own. He revitalized the ethics of Christianity, particularly emphasizing with all the power of his genius the moral basis of the teachings of Christ and his disciples. "Resist evil in whatever form with good only" became the cornerstone of his religious philosophy.²⁸

D. His Inelegant Appearance and Emotion

Tolstoy took up skating at the age of fifty-seven; he performed well in that undertaking, but, like Beethoven with his dancing, dropped such entertainments with disgust. Both Tolstoy and Beethoven were morbidly conscious of their inelegant appearance both regarded their exterior as forbidding. Over and again, Tolstoy refers to his ugly nose, bushy brows, and awkward carriage. On one of the rather frequent occasions when a woman had rejected his affections, he wrote in his diary, "Regard the society of women as a necessary unpleasantness of social life, and avoid it as much as possible."²⁹ According to Rolland, Beethoven would frequently burst out laughing over his own secret thoughts, and could feel joy and sorrow almost simultaneously; Tolstoy, when tense with emotion or when touched by even a mild emotional stimulus, would start crying. He was nicknamed "Lyova Ryova (Weeping Leo)."

E. His Reticence In Love

At thirty-two Tolstoy was still a bachelor. At this time a page in his diary reads: "I shall seek the company of persons who stand higher on the social level than I . . . always to dance with the most important ladies . . . never to lose presence of mind, but to continue the conversation . . . to be as cool as possible, and to show no signs of emotion." But another page of his notebook reads: "Pig! I played roulette from morning until night. Lost, but toward the end of the day . . ." Next day the entry will tell: "Roulette until 6:00. Lost the last penny. Am suffering terribly. Am no good."³⁰

Sophia Bhers, whom Tolstoy eventually married, seemed the girl of his heart and mind; but, having suffered fiascos in love, he feared being turned down by her. For three weeks in succession he saw her every night, and stayed until the early hours of the morning, but could not gather enough courage to propose to

her. Another page of his journal reads: "Today I will ask Sophia to marry me." But the self-revealing and self-dissecting author records the next day: "I didn't do it. I will tomorrow. As soon as I get up I will go to her or kill myself."³¹ At long last, on the fourth week, he handed her a letter which read: "Sophia Andreevna: For three weeks I have been leaving your house with the same vexation, repentance, and fear. I am taking this letter with me in order to give it to you, should the courage to speak fail me again."³² His courage to speak did fail him again! The letter he handed her read: "You, the honest person you are, tell me with your hand on your heart, and without hurry, I implore you — do you want to become my wife?" That night after he reached home, he jotted down in his journal, "Said it. She: Yes."³³

F. Not Inconstant in His Literary Creation

One biographer refers to Tolstoy as the inconstant genius.³⁴ Indeed, Tolstoy was inconstant — in everything except in the field of literary creation. Like Beethoven, he seemed to have become overwhelmed by irresistibly intruding thoughts and ideas. His wife stated in her methodical journal that his diet was quite ridiculous: "He eats rich food one day and vegetarian food the next, and rum and water and what not."³⁵ But Tolstoy, the literary genius, was a different person. He worked continually for five years on *War and Peace*, and re-wrote portions of *Anna Karenina* twenty-eight times. Just as each musical theme in the Ninth Symphony is perfect in itself, blending harmoniously with that which precedes and that which follows it, so, too, is each of the eighty-three characters in *Anna Karenina*, and the innumerable ones in *War and Peace*. Often the individuals disappear when the reader has had only a glimpse of them; when they reappear, they blend into a harmonious picture in which joy and sorrow, failure and success enter at the proper moment and place; the reader merges with each of Tolstoy's personalities, just as he

becomes imbued with the music of the Ninth Symphony.

G. Disinterested in Academic Learning

According to Nazaroff, whatever Tolstoy speaks about, "whether it be a human being, a dog, or a lilac bush," he does not describe it. He seems to sense it from within, and he tells what he senses with a conviction which can be derived only from personal experience.³⁶ Paradoxically enough, he was utterly disinterested in academic learning, and at the end of his freshman year at the University of Kazan, which was then Russia's center of learning, Tolstoy flunked every subject he took. But he became a linguist of no small stature. He spoke French and English faultlessly, and could write in them almost as well as in his native tongue.

H. His Life Revealed in Person of Levin

Tolstoy reveals much of his innermost life in the person of Levin, one of the principle characters in *Anna Karenina* and in Niechludoff in *Resurrection*. His wife's faithful diary also sheds much light on the inner man of Tolstoy. "Our life in Moscow would be enjoyable if only it would not make Lyova (Leo) so unhappy . . . He cried out aloud today that his most passionate desire was to get away from his family . . . he is full of Christianity and the ideal of self-perfection . . ." And the same manuscript records at a later date: "For the first time in my life Lyova has run away from me and has spent the night in his study." Yet on another page, "Golokhvastov spoke with great pathos about the marvelous cathedral in New Jerusalem (Voskresensk) which was wonderfully built and could hold ten thousand people. Leo Nikolaevich listened for a long time, then suddenly said, 'They all go there to have a laugh at God.'" And again she records, "Lyova is in his dark hours again. He is very cold and reserved with everybody — sometimes for days, weeks, and even months on

end we hardly exchange a word . . . As a matter of habit I run up to him with my own thoughts and concerns — the children, a book — but he meets me with a cold, surprised, forbidding look: 'You keep bothering me with your nonsense.' . . . I keep watching Lyova; there is so much to him — such talent and intelligence, and yet so little of the sense of self-preservation; everything excites and tortures and worries him."³⁷

I. His Long Periods of Depression

Tolstoy suffered for long periods, but try as he would, he could not run away from self and family. The instinct of self-preservation struggles in genius, and so it was with Tolstoy, in spite of his wife's remarks to the contrary (he lived until the age of eighty-two). Commenting on these painful and lasting struggles, Michailovsky says, "If an ordinary man were in such a position, he would have ended in suicide or in drunkenness. A man of value will, on the contrary, seek for other issues, and of such issues there are several."³⁸ During the periods of hypomania, Tolstoy indulged in wine, women, and song; during the periods of depression he sought escape from the onslaught of destructive thoughts in philosophy, social education, and agrarian reform. He talked of liberating his serfs, but, like many other contemplated projects, never got around to it because he got over his depression. Beethoven would say, "I must write my music;" Tolstoy would exclaim, "I must write!"

Aristotle must have known a Ludwig van Beethoven and a Leo Tolstoy when he said, "There is no great genius without a mixture of madness." The persistent urge for self-destruction — not to be confused with the hysterical attempt often seen by the physician when a patient craves attention from beloved, husband, or parent — is in the great majority of instances a symptom of madness, much as we may dislike the term.

Tolstoy had many other symptoms of a manic-depressive

malady. When the fire of genius wore itself out periodically, the ensuing smolder was either a hypomania or a depression. In both geniuses the greater component of mania was Hypo, and that of depression was Hyper. Beethoven was at the apotheosis of creation when he improvised, and he improvised much of the time; Tolstoy was at the bottom of his depressive phase when he denounced art and civilization, and when he would castigate himself for being a "legal robber" by not giving his serfs their God-created land. He often disappeared from home dressed in peasant apparel, usually a rough kaftan, ill-fitting and ugly boots, exclaiming repeatedly, "All is vanity!" In those periods he would often try to emulate the nature worship of Rousseau.

Tolstoy was a more than amateur pianist. Another page of his wife's diary, which she kept for twenty years, reads: "Lyova is once again the same happy, joyful father of the family. The other day he spent the whole evening playing Mozart, Weber, and Haydn, and one could see how much he was enjoying it. He is looking happy and full of energy, and often says, 'Life is a fine thing.' " ³⁹ In his book, *What is Art?*, he vituperously attacked Beethoven's Kreutzer Sonata. Its beauty of color and tone which inspires the soul of the musically inclined, as well as that of the average listener, evoked in him only a feeling of revulsion. ⁴⁰ Tolstoy's periods of depression lasted for months, and during one period of his life he was in a state of depression for three years. It was most likely during such a prolonged period of depression, when his keen intellect was blunted, that Tolstoy wrote: "What! The Ninth Symphony not a good work of art? I reply, most certainly it is not!" ⁴¹ "In music," he says, "besides marches and dances by various composers, which satisfy the demands of universal art (he uses this term as synonymous with religious art, the only true art), one can indicate very few works of this class: Bach's famous violin aria, Chopin's Nocturne in E Flat Major, and perhaps a dozen bits (not whole pieces, but parts) selected

from the works of Haydn, Mozart, Schubert, Beethoven and Chopin."⁴² Of his own literary creations, he says, "I consign my own artistic productions to the category of bad art, excepting the story *God Sees the Truth*, which seeks a place in the first class, and *Prisoner of the Caucasus*, which belongs to the second."⁴³

J. Tolstoy's Estimate of Abraham Lincoln

An interesting sidelight of the stature of Tolstoy can be viewed from what he thought and felt about another great manic-depressive — the rail splitter from Springfield, Illinois, who became the embodiment of all that is great and noble in man — the sixteenth President of the United States. "The judgment of the world is usually wrong in the beginning, and it takes centuries to correct it. . . . We are still too near his greatness, and so can hardly appreciate his divine power; but after a few centuries more our posterity will find him considerably bigger than we do. His genius is still too strong and powerful for the common understanding, just as the sun is too hot when its light beams directly on us." And he continues: "Abraham Lincoln was what Beethoven was in music, Dante in poetry, Raphael in painting, and Christ in the philosophy of life. He aspired to the divine, and he was."

Tolstoy was fascinated by the lines in Abraham Lincoln's face, and had a number of photographs of him. On one of his travels in the Caucasus, Tolstoy had occasion to discuss the author of the Gettysburg Address with a tribal chief. The horseman became greatly impressed with Tolstoy's verbal picture of Lincoln; Tolstoy, in turn, was equally impressed with the interest of the Cossack, and the fact that something was stirred up in his soul. The chief of the tribe presented Tolstoy with one of his best horses in token of appreciation of his visit. The author of *Anna Karenina* was greatly touched by the incident; he decided to leave his host an appropriate reminder of Lincoln, and traveled a considerable distance through a number of Caucasian towns before finding a

photograph of the President. Upon giving it to the rough mountaineer tribesman, Tolstoy regarded him intensely as he was absorbed in the photograph, then asked why he had become so sad. "Don't you find," the Caucasian replied, "that his eyes are full of tears, and his lips are sad with secret sorrow? And I feel sorry that he had to die by the hand of a villain!" To Nazaroff's characterization of Tolstoy, that whatever he speaks about — a human being, a dog, or a lilac bush — he seems to sense it from within, one should add: *Mutatis mutandis* does this apply when a Tolstoy senses a Lincoln?

K. His Urge to Self-Destruction

Tolstoy suffered long and deeply from a recurrent and persistent urge for self-destruction. His works and his diaries are filled with self-accusations: he was unworthy, a sinner, a hypocrite, and consigned to eternal damnation. During those periods of depression, life was indeed ceaseless damnation and, he thought, was beyond his endurance; death was the only way out. The author of *Resurrection* had a rope hidden in one place or another most of his life. When in these periods of despair, he looked at himself as a most despicable character. This attitude of Tolstoy toward Tolstoy is responsible for his wanting to hang himself.

Modern psychologists look at the urge or instinct for self-punishment as a very real thing, although, to be sure, it cannot be demonstrated by either an x-ray film, a precipitate in a test tube, or by a percussion hammer. The urge for self-punishment with the vision in his mental eye of his ugly body (as he often spoke of it) dangling from a rope, accounts for his desire to hang in preference to any other form of self-destruction. But Tolstoy also loved life with the love of a great creative artist; and as was pointed out, he was slow in arriving at any definite decision. Fortunately his pathologic indecision and his love for life saved him for mankind!

IV. Peter Ilich Tchaikovsky

A. Musical Genius at Twenty

The fire of Tchaikovsky's genius had a hue all its own. In the words of Henry and Dana Lee Thomas, authors of *Living Biographies of Great Composers*, "he was a genius to whom destiny has given the gifts of a God and denied the power of a man."⁴⁴

Tchaikovsky did not suffer from either the boredom of luxuries as Tolstoy did, or from poverty and adversities as Beethoven did. But a genius he was. At the age of twenty, after he received the degree of Bachelor of Law, and after he served as a legal clerk in the Ministry of Justice, he entered harmony classes at the Conservatory in St. Petersburg. Then the spark which had lain dormant for twenty years burst into flame. Within one year after he entered the Conservatory, he composed his first symphony and his first opera; one year later, he was appointed professor of harmony at the Moscow Conservatory.

B. Symptoms Were Psychosomatic

Tchaikovsky was, like Beethoven and Tolstoy, a victim of mania-depression, only his symptoms were primarily psychosomatic in nature: heart cramps, indigestion, head noises, and a sensation that his head would fall off his shoulders. The latter occurred most often when he would be in a crowd or after he had conducted at the Conservatory.

Then, too, there was the Tchaikovsky special "syndrome" — his need for "curative" waters. "This coming summer," he writes in December, "I plan to work very hard and take a cure. Last year I drank the waters at Vichy and found them very good for me physically. Probably toward the end of the summer I shall go to Essentuki in the Caucasus, where the waters are much the same as at Vichy."⁴⁵

But Melancholia was the constant overshadowing symptom. At times this reactive depression reached its nethermost depth; during those periods the most trivial emotional oscillation was enough to throw him out of mental and emotional gear.

I am emphasizing the symptom, *heart cramps*, because to many the heart is the seat of emotion, passion, affection, sufferance, and inspiration. Tchaikovsky knew that his heart in the sense that this organ, as the opposite of the intellect, was not serving him properly. At least half of mankind—women—were repulsive to him; he had neither eyes nor ears for them; and worse yet, he had to pretend that he had. The heart cramps, indicate, as one would say in Russian, "A thin hint bespeaks a thick circumstance."

C. His Homosexuality

The exact etiology of manic-depression, as was said in the first chapter, is still unknown. There is probably a constitutional pre-disposition, the *Anlagen*, as the Germans say, but thwarting environmental factors are always present. Tchaikovsky's homosexuality was that thwarting environmental factor. It was at the bottom of his conduct—both the conscious and the subconscious.

In the middle of the 19th century there was no psychological explanation for this form of human feeling and behavior. No one even attempted to understand it; socially, morally, and legally, it was considered a reprehensible crime punishable by imprisonment.

Tchaikovsky had a special name for his "affliction." Barbara Von Meck, co-author of the book, *Beloved Friend*, and daughter of the woman whose influence upon Tchaikovsky's creative life will be explained later, uses the English word "The."⁴⁶ This writer is of the opinion that "It" would be better, but inasmuch as that splendid book uses "The," I follow the example. When Tchaikovsky was about to accept a job as meat inspector, when he was serving as a clerk in the Ministry of Justice, or when he was

seriously considering a monastic life, his purpose was always to choose the lesser evil: a situation where "The" would disturb him least. His entire family developed a special sense for avoiding, evading, and ignoring everything which, even in the most indirect way, hinted at homosexuality. They, and others who loved him, destroyed almost all first-hand information about Tchaikovsky, the child or the man.

Of the meager authentic knowledge about his childhood, two episodes make the nature of his heart cramps, and of his entire life, more understandable. Once, during his early teens when he was in St. Petersburg, his mother left home for a short while. As her carriage rolled away, he extricated himself from his father's clasp and grabbed the hind wheels. He was not going to be left alone; he could not forbear his heart (his mother) to leave him. By a miracle he was saved from being crushed to death.

On another occasion in the schoolroom, he passionately kissed the area of Russia on a map and spat on the other countries. When his teacher told him that she was born in France, that it was a beautiful country, and that she loved it, he instantly put his hand over that area and exclaimed, "But I covered France with my hand!"⁴⁷ The adage that "the child is father to the man" is reflected in Tchaikovsky's ability to change instantaneously from a Dr. Jekyll to a Mr. Hyde — "But I covered France with my hand." His eclectic style of composition, his sudden changes in musical themes, are as beautiful in themselves and as "cute" as his answer that he covered France with his hand.

Later in life Tchaikovsky would energetically brush his beard to stretch it to a maximum length; he often frowned (basically, he was the kindest of men) to give his naturally high forehead greater dimension. His large, kind eyes seemed piercing; they were, as the Russians say, *ymozriteli* — mind reflectors, or mind lookers; he was always searching for the reason that fate had denied him the power of a man. His mustache could without

offense to Buffalo Bill or Rimsky-Korsakov, be called a mustachio. He was fond of wearing gaudy clothes.

Homosexuality affected Tchaikovsky in every move and every gesture he made. His habit of chewing up things such as paper and pencils was a subconscious mechanism — an attention device to keep peoples' eyes on what he was doing and not on what he was. When a clerk in the Justice Department, he once carried a legal document to another part of the building for signature by the proper official. On the way he encountered someone he liked, and they began talking; by the time the conversation was over, the instrument, as the lawyers would call it, was chewed to pieces. Fortunately, there was another copy, and Russia's great composer was able to keep the wolf away from his door for several months longer. He could out-drink all his colleagues, and there was, indeed, method in his madness. He always knew what he was talking about, and at all times had his "head on his shoulders and his feet on the ground." He lived in terrific fear that, as the Russian proverb goes, "that which is in a sober man's mind is on the tip of a drunkard's tongue." The fear that something about "The" might come to the surface kept him sober, and paradoxically enough, he saw to it that his fellow drinkers would drink more and more. He was always very generous with money, but ever so much more so when treating others to drinks. "Have another," constituted a considerable part of the conversation.

Likewise, the homosexuality gave Tchaikovsky's music a peculiar tinge. There still is no uniform opinion among music critics as to whether Tchaikovsky was typically a Russian or a Western composer. He was neither. He was primarily a very sensitive man with a terrifically painful, ragged scar on his heart and his mind — his homosexuality.

No great homosexual ever tried harder to conquer this form of perversion than the creator of the *Symphonie Pathetique*. To

his brother, Modest, who was probably suffering from the same disorder (whom he always embraced and kissed affectionately, always weeping whenever they parted even for a short period), he wrote, "I have now to pass a critical moment in my life. By and by I will tell you about it more fully; meanwhile, I must just tell you that I have decided to get married. *This is irrevocable . . . only my persistent work keeps me from desperate depression.*" ⁴⁸

But months afterwards, he wrote, "Dating from today (September, 1876), *I shall make a serious effort to legally marry anybody.* I must fight my nature with all my strength . . . I shall do everything possible this year." ⁴⁹ Leo Tolstoy could not muster enough courage to ask his future wife to marry him, so he fortified himself with a letter which he handed her after seeing her regularly every night (and parts of days) for three weeks; Tchaikovsky, by way of further self-reassurance, writes on a later date, "*And if I am not brave enough for that* (meaning a complete married life in the widest sense of the word — not only a physical one), at any rate I shall conquer my habits once and for all." ⁵⁰ Here he reveals a gross lack of understanding of the nature of his problem. He thinks that a deeply psychological attribute can be eradicated by a mere physiologic release of an instinct.

Again alluding to the "The," he writes later yet, "There are people who do not despise me for my vices only because they began loving me before they suspected I was only a man with a lost reputation. Is it not a bitter thing to be pitied and forgiven, when, truly, I am in no way guilty! So it has been a hundred times and will be a hundred times more. In a word, I should like to marry, or by some known liaison with a woman, shut the mouths of all despicable gossips for whose opinions I do not care a bit, but which can hurt people close to me." ⁵¹ Again he pours his heart out: "I am so confirmed in my habits and tastes that to throw them away as one would an old glove is impossible." "Then," once

more he pleads, "I have far from an iron will." ⁵²

D. His Woman Benefactor

No sketch of the author of the opera "Eugene Oniegin" is possible without mentioning the woman who was largely responsible for Tchaikovsky's continued musical creations. That woman was a widow, Nadiejda Filaretovna Von Meck — the Rockefeller of Russia of that day. She was greatly moved by all of Tchaikovsky's music, and to make possible for posterity to have his music, she bestowed upon him an income of six thousand rubles a year, amounting then to the equivalent of fifteen thousand dollars or more a year. For thirteen years she supplied him regularly with that amount.

The widow and Tchaikovsky never met — this was agreed upon in writing. Physical contact, Tchaikovsky informed Madam Von Meck, might be disturbing to his complete freedom from even a thought that he was writing for money, or that he was a commissioned composer. The wealthy patroness of his music could see no reason that an occasional meeting or hand-shake, or his presence at small family entertainments such as a child's birthday party (he lived many summers in a cottage she furnished for him, only a block away from her), would interfere with his freedom to create, but she acceded to his wishes. But a chance encounter was bound to occur. One day as she was riding along the same route he had taken for a pleasure drive, the two (even though in separate open carriages) found themselves in a tete-a-tete position. Tchaikovsky was startled; he had an impulse to raise his hand and greet her with a smile; but by the time his hesitating mind could decide what to do, the carriages had passed each other, and they had exchanged neither word nor smile.

Tchaikovsky dedicated his Fourth Symphony to that generous soul, who was generous not only with money, but with patience and encouragement — always mindful that he could be touched

to the quick by a word or a gesture. Without the aid and friendship of that noble lady, Tchaikovsky would have died with much of his music in him, as he once expressed it. In many of his letters to her he repeatedly referred to his Fourth Symphony as "our" symphony. "Perhaps I am mistaken," he says in one of those letters, "but I think this symphony is something out of the ordinary — the best thing I have done up to now." ⁵³ One of his colleagues speaks of it as "nothing but a melody from God." ⁵⁴ But another musician of the day, a friend of Tchaikovsky's, told him after the performance in Moscow, "The first movement was too long. . . . It produced the effect of a tone poem to which the composer had tacked on three additional movements. The result was a hodge-podge, instead of a symphony. Every movement seemed ready to burst into ballet music — stylistic error which spoils the general effect." ⁵⁵

Yet another critic, an Englishman, summed it up thus: "Good and bad. Good points: Beauty of melody, brilliancy of workmanship, beauty of color. Weak points: Undue pursuit of the morbid, extravagance of ideas, noisiness of orchestration." ⁵⁶ Tchaikovsky himself did not always think that his Fourth Symphony was "something out of the ordinary." In one of his letters to Madam Van Meck he says, "What will it say to the listener? Will it live after the composer has disappeared from the earth? I wonder." ⁵⁷

E. The Beautiful Andante Cantabile

The Andante Cantabile from the Fifth Symphony is popular because it is so beautiful. Millions the world over are moved by that something which, for the lack of proper semantics, I shall call the melody or suffering of a beautiful soul. People composed — they hummed — long before they spoke; music has always been composed. It was "on the march" long before the Muscovy appeared on the face of the earth. Soon after Homo-

Sapiens parted company with his progenitor, the anthropoid cousin, he began to "compose," probably humming first, dancing next, finally singing. Savages of the lowest cultural level have a very limited vocabulary, but their dance "music" is as perfect as the best of their composers can make it.

F. His Passion for Music

Tchaikovsky had more than one thing in common with the manic-depressive Beethoven. Like the lowly immigrant from Belgium, he was equally proud, yet as shy, equally affable, yet as arrogant and prohibitive. But more than anything else, they had their music. "I must write my music," says Beethoven; and Tchaikovsky laments, "I am of no use except for music. I am afraid I shall die with my music in me. To compose is for me a kind of musical shriving of the soul."⁵⁸ It is very unlikely that Tchaikovsky knew anything more of the life of Beethoven than what he could hear in his music — hence, the similarity in their love and feeling about it becomes more striking.

G. His Alcoholism and Abulia

Pathologic alcoholism, as was pointed out, is a frequent occurrence in a certain type of individual who suffers from mania-depression. Tchaikovsky was no exception. "I have hidden something from you," he wrote to his brother, Tolia; "Since the day you left me in Vienna, every evening before bed I drink several glasses of brandy, and during the day I drink a lot, too. I can't live without it. I am calm only when a bit tipsy. It is proof that I am not yet well."⁵⁹

Pathologic indecision — Abulia, as it is referred to in psychiatric parlance — is common in manic-depression, and Tchaikovsky had his share of this symptom. At a later date yet, he tells his favorite brother, Modest, in a postscript, "I am not inclined to hurry this matter (that of marriage). You can be sure *if* I

really *tie* myself to a woman, I shall do it with great prudence.”⁶⁰ But abulic and “prudent” Tchaikovsky could not resist Antonina Miliukova, the schizophrenic girl he married. It would take the power of imagination of a Rabelais and a Dante combined to imagine how the shy, eternally fearful Tchaikovsky felt when he would receive letters from her — spotted with blood stains in token of her love for him. The blood (which came from biting her fingernails to the core), she assured him, came from her heart, which she was anxious to give him, preferably while she was living; but should he reject it then, she would present it to him just the same — she would commit suicide. (Antonina kept her promise; she committed suicide in an insane asylum.)

H. His Marriage Was Abhorrent

In a letter to Madam Von Meck he confided about his marriage, telling her of his feelings in these words: “The instant the ceremony was over, and I found myself alone with my wife, realizing that our fate was henceforth to live inseparable and together, I knew suddenly that I felt for her not even simple friendship, but that she was abhorrent to me in the full sense of the word. There came to me the conviction *that I, or rather the best and perhaps the only good part of the being that is I — music —* had perished forever . . . all that is left is to pretend. But to pretend all one’s life is the height of torture. How could I ever work? . . . Death seemed the only way, but death by my own hands would deal all I love a death blow. . . Then I have the weakness (if one can call it a weakness) to love life, love my love, my future success. I have not yet said all I have to say, all I want to say before the time comes to migrate to Eternity.”⁶¹

I. Nearly Committed a Murder

Tchaikovsky sincerely wanted to die in order to get away from the *The* which pursued him relentlessly and as cruelly as

Javert pursued Jean Valjean of the immortal *Les Misérables*. Tchaikovsky would do anything within his power to rid himself of that monster, but he could not commit murder; he came near, however, committing two. He plunged into the Moscow River one late October evening, and there he stood for hours, oblivious to the piercing and beating cold waves, very much like Beethoven had been during the Royal procession in Teplitz. When Tchaikovsky came out of that gloom, he went home, engrossed in only one hope: that this would result in pneumonia, then a "natural" death! This, it should be remembered, occurred in pre-sulfa and pre-penicillin days; Tchaikovsky had good reason to believe that all would soon be over. Fate declared otherwise. Upon reaching home, his boots and clothes covered with a film of ice, Antonina was horror-stricken at the sight of him.

The startled creature tried desperately to help him undress and put him to bed, and in despair she implored over and over, "What happened, Dear Heart?" The sound of the word "heart" prefixed by "dear" threw him into a mental convulsion; suddenly he was charged with a demonical urge to avenge the "The" by striking a death blow to his wife, whom he had hoped would be the means of freeing him from its clutches. He became obsessed with the idea of choking her to death, but the nimble fingers that could create such melody as his from the keyboard could not snuff out a human life. As she persisted in caressing and kissing him, he tore himself away from her, put both arms behind his back, stretched himself out full length, and began to roar, emitting horrible sounds. This lion-like raving released the excess of pent-up energy, and brought about the physiologic trick which averted a horrible tragedy — murder.

(The greatest conductor of our day was once conducting a dress rehearsal of his orchestra. For reasons known only to himself, the concertmaster insisted upon playing out of tune. Over and over the maestro began anew, but to no avail. Finally, he descend-

ed from the podium, coming as close to the first violinist as possible, and begging him to play in pitch. This very plea brought on a violent outburst, and he began to beat his chest in a crescendo manner — "Please play . . . please play. . . ;" everyone in the orchestra thought he would fracture his ribs. The first violinist promised to violate the rules no longer. The rehearsal over, the maestro whirled his baton into the concert hall and started to run full speed to his apartment. When he reached it, he broke everything he could lay his hands on. This was his only means of releasing tension in a state of emergency.)

J. Had a Horror That Someone Would Detect His "The"

The horror Tchaikovsky had lest someone might somehow catch a glimpse through the mask of the "The" is illuminatingly illustrated by an incident that occurred after he first met Leo Tolstoy. The verbal smasher of all "bad" art heard Tchaikovsky's Andante from the D Major String Quartet when Nicholas Rubenstein arranged a special musicale for Tolstoy on one of his visits to Moscow. He was greatly impressed with it. "I never had such precious reward for my literary labors as on that wonderful evening," ⁶² the author of *War and Peace* wrote the composer, offering to give each quartet member, as well as the composer, one of his books in appreciation of the fine performance. The creator of the Andante replied, "Our quartetists played as never before, which proves that one pair of ears, if they belong to an artist as great as yourself, can inspire musicians more than a thousand ordinary pairs . . . all the quartetists would be very grateful if you gave each of them one of your books. For myself, I would like best to trade *"The Cossacks."* ⁶³

Another lapsus linguae! He, the most effeminate of men, chose *The Cossack* — a story which depicts the horsemen who lived by the sword, and who at leisure would laugh, sing, and dance; and, should fancy strike the Cossack that he must have the woman he

desired (always under the guise as the woman he loved), he would have killed his competitor with as much gusto as he would strike down an enemy or perform the famous dance, the *Kozatzky*. With an apology to the memory of this kindest man, who suffered because he could not hurt others, Tchaikovsky's request for *The Cossacks* brings to mind one who proclaimed himself "*Il Duce*." "Of all the domestic animals," said Benito Mussolini, "I like the cat best. I like it for its independence, its quickness in decision, and for its gracefulness in execution of movements."⁶⁴ *Il Duce*, as history has already recorded, became a puppet of the Austrian corporal, Adolph Hitler, at whose order, in the words of Winston Churchill, he stabbed his neighbor, France, in the back.

Peter Ilich wrote to his brother, "When I first met Tolstoy, I was possessed by fear and a feeling of uneasiness that this great searcher of hearts could pierce at a glance every secret of my heart . . . before him a man could not hide the nastiness that lurks in the lowest depths of every soul, nor could a man put the best side upon it. I told myself that if Tolstoy proved kind, then purposely, like a physician with his scalpel, he would delicately probe my wound, seeking instantly the sorest spots and avoiding them; and this very avoidance would prove that nothing was hidden. Or, lacking compassion, he would lay his finger on the very center of pain. I was terribly afraid of these two things. Neither occurred. He, in conversation, proved simple, sincere, wholehearted, making no parade of the omniscience I had feared."⁶⁵

K. Honors Mixed With Melancholy

No other composer — at least, no other Russian composer — has had so many honors bestowed upon him, when still living, as the creator of the opera, *Romeo and Juliet*. He was elected a member of the Academie Francaise, was given an honorary degree by Cambridge University, and was invited to give concerts in six

leading American cities. But the cruel voice of melancholia kept on whispering into his sensitive ears, "These are all empty laurels. You are done with — you *are* an *homme fini*!" Like the last flicker and sputter of the candle before it becomes extinguished, to paraphrase Elizabeth Barrett Browning, "Let the ether go surging 'neath thunder and scourging of wild winds unbound," his brain and heart began to pulsate in a hitherto unknown manner — "I must write one more symphony — my last! I must tell the world all my sufferings — how *I, myself*, feel about the thing which caused these horrible cramps, dizziness, and feelings that my head would fall off my shoulders." ⁶⁶ Again, to his brother, Modest, he says, "It seems that Peter has ceased to belong to himself. Some irresistible force has taken possession of him . . . a deep, inexplicable anxiety, a mood of despair that sought forgetfulness in distraction anywhere and everywhere." ⁶⁷

It was indicated in the first chapter that the psychiatrist is never heedless of a patient who threatens suicide, particularly when that patient repeats these anticipated thoughts. The underlying psychological mechanism for the patient's self revelation has been explained, even though briefly. If there is a rule to things regarding human conduct, Tchaikovsky was the rule and not the exception — he was full of morbid fears, and often spoke of the bliss of death when one knew he was growing prematurely old and losing his creative powers — that he was an *homme fini*. This is the cry of the melancholic. He is often in the abyss of depression when all about him seems cheerful, glorious, and full of excitement!

L. The Symphonie Pathetique and the Fatal Glass of Water

All this he told the world in his last work, the Sixth Symphony! His brother, Modest, who knew more about him than any other living soul, suggested that he should name his final message in music *Symphonie Pathetique*. With the same innate artistic honesty as Tolstoy depicted himself in his writings, Tchaikovsky says

about this composition, "I believe it is the best of all my works to date; at any rate, *I know it is the most sincere.*"⁶⁸ Nine days after he conducted this last symphony, he told his friend and contemporary composer, Glazunov, that for the first time in his career, he had come away from hearing one of his compositions with "a feeling of complete content."⁶⁹

The music of the Pathétique, as its name implies, was Tchaikovsky's repeated allusion to the belief that he was soon going to die. The farewell message was told when Russia was scourged by the plague of cholera; it claimed the lives of hundreds of thousands. Every intelligent man and child in those dark days knew the danger of drinking unboiled water. Tchaikovsky ignored this precaution! Ten days after he conducted the Pathétique Symphony, he was laid to rest — five days after his fatal drink of a glass of unboiled water.

Like Beethoven, who could feel joy and sorrow almost simultaneously, Tchaikovsky, shortly after he had reached the pinnacle of his desire to tell his suffering to the world and posterity, was laid to rest. The words he mumbled in the final agony of delirium were "Nadiejda Filaretovna," the name of the woman who, perhaps alone, was instrumental in his being able to create about a hundred beautiful songs and a number of more intricate and equally beautiful musical compositions. It was the rich widow — that aristocrat of mind and character — who made it also possible for Tchaikovsky to give to the world a farewell with a hue all its own.

Descartes might have been right when he formulated the maxim, *natura non facit saltum* (nature makes no jumps) — but the soul, nature's final product (or is it a by-product?) does make jumps. Tchaikovsky jumped into eternity after he told the world with all his fiery genius "the beauty of his sorrows" in his *Symphonie Pathétique*. Professional critics, using magnifying glasses, may find faults either in its overtones, undertones, or in the orchestra-

tion itself; but the human heart, the uncultivated human heart, hears and feels countless haunting but beautiful tunes — noble horn themes in the slow movements, and almost unendurably stirring violin themes throughout. After the last melody is played, the possessor of that heart feels himself a better being for having heard the music of the majestic Tchaikovsky in sorrow.

The profound feeling of guilt, coupled with the urge to avenge the *The* by suffering, lends more than circumstantial evidence to the ironical thought that Tchaikovsky at last succeeded with a glass of unboiled water in what he had failed to achieve by plunging into the Moscow River. *Sic transit gloria mundi!*

V. Charles Dickens

A. Marks of a Genius

Charles Dickens is advisedly discussed last in this series of sketches, but to this group he belongs, for he was a genius. Like the three predeceasant characters, he suffered from mania-depression, but in his case the greater component was Hypomania. Dr. C. S. Bluemel of Denver speaks of hypomania as a condition in which the individual is "*supercharged* with energy and activity;" and this, it should be recalled, is part of the symptomatology of mania-depression. In the ordinary man, the hyper-activity and hyper-reactivity to everyone and everything about him, and the ceaseless stream of ideas, usually dwindles away into nothingness. It recurs over and over, only to disappear into the air once more. But in the creator of *Oliver Twist*, it was the power which made him financially independent at the age of twenty-one. He was more than well-to-do by the time he was twenty-five, and at fifty-eight when he died, he left over 93,000 pounds — in terms of the dollar value of today, that is about \$651,000 — a tremendous sum in his day. And Dickens was anything but a miser — he had his full share of poor relatives whom he helped generously and for long periods of time.

B. Dickens Family Background and Shame of Poverty

Dickens was the grandson of a footman who gradually elevated himself to a butler, but his grandmother remained a housekeeper throughout her natural life. Charles' father, John Dickens, was a jovial, carefree individual — a liberal money-spender who cared little of whose money it was. He always had a good story on the tip of his tongue, and an appropriate jest for his creditors whenever they asked for their money. When Charles was only nine years old, his father's creditors refused to accept any longer his jocularly in lieu of money; and as a prophylactic measure, threw him into Marshalsea Debtors' Prison. He enjoyed looking at his creditors from behind prison walls, instead of seeing them face to face.

Dickens had many things in common with Beethoven—the latter's father having been a chronic alcoholic, and Dickens' an irresponsible individual, somewhat of a schemer, and a contented prisoner — as long as his wife brought him his favorite dishes every Sunday throughout his two years' confinement. Like Beethoven, Dickens knew poverty and its concomitant insecurity, fear, and envy; and like the creator of the Ninth Symphony, he was morbidly ashamed of his poverty. At the age of ten, Charles was hired out to a blacking factory as a child laborer. He hated this work, which, in his own words, was "to cover the pots of paste blacking — first with a piece of oil-paper, then with a piece of blue paper — to tie them round with a string; and then to clip the paper close and neat all around, until it looked as smart as a pot of ointment from an apothecary's shop."⁷⁰ The dirtiness of his hands and face from licking numberless labels was repulsive to him, for he was innately meticulous in his personal appearance.

It must be the enigma of genius that great "searchers of hearts," to use Tchaikovsky's words could be so morbidly conscious and ashamed of things for which they are utterly blameless. The scarlet waist-coat, apple-green trousers, and equally loud

tie with which Dickens startled the Bostonians on his visit to the U. S. in 1842, were a subconscious compensation for the days when he worked in the blacking warehouse — when he was feeling black and could see nothing but gloom all around him. *David Copperfield*, Dickens' more than a century-old story which is still as new as if it had been born but yesterday, was created when he was nearly middle-aged; most critics speak of it as autobiographical. In it we read the bitterness, shame, and humiliation he felt when he labeled pots of blacking from early morning until late at night. He is ashamed to refer to those blacking-factory days as if he were guilty of a deliberate reprehensible mal-doing. But he was an artist; and once he started to paint the characters of which he was the central figure, he could not leave out the role his father played, referring to him in one mood as Micawber, and in another as Dorritt in Marshalsea Debtors' Prison. In speaking directly of him in non-fiction, Dickens says, "The more I see of him, the better I think him to be"⁷¹ — an illuminating little slip of the tongue.

C. Champion of the Poor and Against Society

The fact that Dickens is placed at the bottom of this ladder of four geniuses should not minimize his greatness; to the contrary, it enlarges his stature, even though, unlike Tolstoy, he did not re-write any of his books twenty-eight times. The hypomania turned them out in factory-like manner, like the baker pulls his loaves of bread out of the oven. It makes one marvel that with no more education than two years in a private school, by sheer reading of a few books, even though they were among the best then and since — the works of Smollett, Scott, Ben Jonson, Cervantes, and Shakespeare, he could learn as much as he did about human nature. But there, again, is that enigma, genius. Those from whom he learned most were people of low life, the people of the streets whom he had seen in the neighborhood of the debtors' prison.

But after all, people *are* more alike than different.

For the so-called "opera class" — the underprivileged rich — he had no understanding, therefore no sympathy, and he gave them very little space in his works. At one time the author of *A Tale of Two Cities* said, "I declare I never go into what is called 'society' that I am weary of it, despise it, hate it, and reject it. The more I see of its extraordinary conceit, its stupendous ignorance of what is passing out of doors, the more certain I am that it is approaching the period when, being incapable of reforming itself, it will have to submit to being reformed by others off the face of the earth."⁷² The poor people, probably because he converted their poverty and their lives into wealth, material as well as spiritual, concern him most. In defense of the pleasures of the poor, he declared that "God had given ale and rum as well as wine to make glad the heart of man."

D. His Fashionable Dress

A London magazine of the day carried a picture of two great Victorians, Dickens and Disraeli, representing the ideal of fashionable masculine dress. There Dickens stands in a tall silk hat beneath which a mop of thick curly hair extends beyond the brim, and in a beard and mustache of full size. In artistic pose he exhibits prominently his right hand and thumb, his white vest, and a massive gold chain, beautiful in contrast with the cane he leans on. And, of course, he wears a black coat and black patent shoes. "Vain," one of the adjectives a biographer, Pearson, used to describe him,⁷³ is indeed the thought one gets as he looks at Dickens. The other great Victorian, the statesman, Disraeli, who was reputed to be one of the four most over-dressed Englishmen, appears, by way of contrast, as if he might be Dickens' personal secretary.

E. His Acting

Just as Tchaikovsky had a special syndrome all his own, everything of Dickens' — his humor, pathos, and horror — are inimitably Dickensonian. Like Tolstoy, who was a genius plus a very able linguist, Dickens was a novelist plus a great actor. It is perhaps more correct to say he was a great actor who acted out his characters on paper, and, under the slightest pretext, on the stage. His earliest ambition was to become an actor, and he studied under a professional. He worked long and hard sitting before a mirror practicing facial expressions for various emotional situations: joy, sorrow, failure, success, enthusiasm, elation, and despair. (The great English philosopher and biographer, Carlyle, after having met Dickens when he was still known as "Boz," said, "He is a fine fellow, Boz, I think. Clear, blue, intelligent eyes that he arches amazingly. . . a face of the most extreme mobility, which he shuttles about — eyebrows, eyes, mouth, and all — in a very singular manner while speaking." ⁷⁴ Carlyle did not know of the long hours Dickens spent in perfecting the art of facial expression.) But fate intervened. On the appointed day for his audition at Covent Garden Theatre, he contracted a cold and was too ill to keep his engagement. Seemingly, his career on the stage was over.

But in reality he never stopped acting. On his second tour of the United States when he was past fifty, it was the acting out of his characters in his readings that made him popular and packed the lecture halls to capacity. In those audiences one could find plebians and patricians, common people and the intelligentsia. And all were bubbling with enthusiasm, admiration, and respect for his performances. If there is truth to the saying that actions speak louder than words, his acting on that last U. S. tour proved that truth. It bears repetition: Charles Dickens was a great actor who acted out his best characters on paper first, and on the stage

next. "I have been Tom Jones . . . for a week together." ⁷⁵ "I have sustained my own ideas of Rodenix Random for a month at a stretch." ⁷⁶ And he was Don Quixote, the Vicar of Wakefield, Robinson Crusoe, and many other characters for weeks at a time. Often he was more than one hero several times a day. He lived them, felt them, and acted them on the invisible stage for an invisible audience. He felt all these things keenly and visualized them clearly through his mental eye. I use the word "invisible" in the sense of the vision of a prophet or great scientist, which must not be confused with phantasy or day-dreaming.

Dickens selected Ben Jonson's play, *Every Man in His Humour*, as the first production for his company of players. (Jonson's play portrays the frailties and vices of his time, and is, indeed, a comedy that can safely be placed among the world's best ten.) Dickens also wrote a two-act farce, *The Strange Gentleman*, a comic opera, *The Village Coquette*, and a farce in one act, *Is She His Wife* . . . all produced at St. James Theatre. His acting in *Every Man in His Humour* was much better than mediocre; after it made a sensation at the Royalty Theatre, it was repeated by popular request at St. James Theatre before Prince Albert and "as many of the peerage as could be crowded in." ⁷⁷ It is safe to assume that most of those spectators were good judges of artistic performance.

In one play, Bulwer-Lytton's farce called *Mr. Nightingale's Diary*, Dickens played six different parts: a lawyer, a waiter, a hypochondriac, an old woman, a deaf sexton, and a pedestrian. Queen Victoria was present at one performance, and Pearson says of the event, "The five guineas each spectator paid for a seat might have been to see Queen Victoria, but most likely Dickens." ⁷⁸ In *The Frozen Deep*, Dickens took the part of an "unsuccessful lover who at a moment of crisis, instead of killing his rival, saves him for the arms of his adored and dies as a result of the hardships he has endured, with a blessing for the two on

his lips. . .”⁷⁹ This is not a slip of the tongue, but a crashing fall of his innermost heart and soul. This is how the generous man, Charles Dickens, wanted to be. The author of this drama, Wilkie Collins, commented on Dickens’ performances as leading man: “He played the principal part and played it with truth, vigor, and pathos never to be forgotten by those that were fortunate enough to witness it.”⁸⁰

The people of England can hardly be accused of being hysterical; it was they who attended these readings over and over, who packed the halls by the thousands, rocking them to their foundations with applause. Once, after Dickens acted out the murder of Little Nell, the audience sat for several minutes in utter silence, paralyzed with horror, so realistic was the “reading.” The popularity with which the American public received his performances has already been referred to. How he, the actor himself, felt about it is reflected in these words he confided to a friend: “I cannot describe to you the glow into which I rise when I think of the wonders that await *us* in these *performances*.”⁸¹ (Notice the numerous times he uses the plural, where the situation — minus hypomania — would have been better expressed by the singular. Nothing exists singly for Dickens.)

No heir to human flesh has ever been free from the miseries of the common cold, genius inclusive. And when Charles Dickens got a cold, he became, as only an eternal actor could describe it, “deaf in the ears, hoarse in the throat, red in the nose, green in the gills, damp in the eyes, twitchy in the joints, fractious in the temper!”⁸² About five years before his last tour to the United States, Dickens sustained a mild stroke which resulted in a progressive weakening of his entire left side; but he, who practiced mimicry, knew how to disguise it from his audiences and from most of his friends — and he probably had a good laugh even out of that.

F. His Income for Play-Activity

At the beginning of his fame as a sketch reporter under the name of "Boz," Dickens was getting fourteen pounds a month. Around the age of fifty-seven when he was spending much time giving readings — I repeat, acting out his characters — he was paid 500 pounds for each reading in a night. In those days the pound was equal to \$7.00, giving him the sum of \$3,500 a night. In the middle of the 19th Century, that sum exceeded the amount which any two stars of modern screen or stage get for two nights, according to Denver producer, Arthur Oberfelder.

G. Dickens' Love Affairs

Much has been said of Dickens' ill treatment of his wife. Women, especially — much as they appreciate him as writer and actor — cannot forbear his treatment of the mother of his ten children.

George Sand, who spent much of her life "in search of love," was, according to one of her biographers, "no gentleman in heart affairs,"⁸³ — and neither was Dickens! He loved Maria Beadnell (Dora in *David Copperfield*), Ellen Ternan (Bella Wilfer in *Our Mutual Friend*), and his sisters-in-law, Georgina and Mary. The whisper of the super-ego was persistent and forceful, but the relationship with Mary was certainly platonic, and doubtless it was the same with Georgina. Then there was Estelle, the fictitious Lucie Manette — the girl who bore him a child. But he was a man! Man is always in love with the wife — the woman he creates the moment he becomes love conscious — sex conscious, which does not mean what I would call "stockyard love." "I did feel," he once said, "sometimes for a little while, that I could have wished my wife had been my counsellor; had had more character and purpose, to sustain me and improve me by; had been endowed with power to fill up the void which somewhere seemed to be about me. . ."⁸⁴

Something can be told about a man by the company he keeps and the friends he has, as the saying goes, but a lot more can be told from the nature of a man's work. Often it is impossible to separate the two; this is even more apropos of genius. Few writers exceed Charles Dickens in his idealization of home — the "heap of living" it takes to make a home. His quotation about what he expected of Kate — "*to sustain me and improve me by*" — is not a slip of the tongue, but the cry of his yearning heart and mind.

Love, whatever it is, is often changeable, treacherous, and capricious; fortunately for mankind and womankind, duty is with most of us a permanent attribute, and Charles had more than the average amount of it. This is attested by the fact that after he and Kate separated in 1858, he gave her 600 pounds a year for life — the equivalent of about \$12,000. All of the children except the eldest son remained with their father, and that was their choice even more than the father's. To his daughters, Dickens was the pattern of everything a man stands for in the mental eye of the little girl, the adolescent, and the girl-woman.

People are born to talk, and great people are born to depict their innermost souls in their artistic creations. Few are the geniuses of canvas and brush who have not painted portraits of themselves. The geniuses of words do likewise in their novels. Charles Dickens depicted himself with the honesty of Leo Tolstoy when he spoke of his love and affection toward the woman he knew never loved him — his fifth and last adventure in love. "I never had one hour's happiness in her society, and yet my mind all around the four-and-twenty hours was harping on the happiness of having her with me unto death."⁸⁵ Another great genius, Goethe, married his housekeeper at the age of fifty-seven, but he immortalized the love of his heart, Gretchen, in the persons of Fredrika Brion and Marguerite in *Faust*. Dickens shows us his last love, Estelle, as Lucy Manette in both *A Tale of Two Cities*

and *Great Expectations*. Even Shakespeare's Othello, with all of his Moorish temperament, did not reveal his pain, anguish, jealousy, and anxiety lest his beloved be in someone else's arms, as did the person depicting Dickens himself in *Great Expectations*. His name? Bradley *Headstone* — what else but *Headstone* could his name have been? Dickens was almost thirty years older than Estelle (Lucie Manette).

The greatest psychiatrist of all time who said, "He who is without sin let him cast the first stone," must have known a Charles Dickens enduring the pangs of love. Only he who has never experienced the pangs of the great hypomanic could throw stones at Dickens.

H. Dickens' Unusual Energy

No proper appreciation of Dickens is possible without the approach of the oldest method in medicine, which Hippocrates, born in 460 B. C., practiced, and which has recently been resurrected: the psychosomatic approach. Psychosomatically analyzed, Dickens can be blamed for only one fault — chronic hypomania. A non-professional biographer describes him as possessing energy which is almost frightening. Frightening, indeed, his energy was! He is the chronic hypomanic personified in the world of literature, if not in the world of all the creative arts. Only a hypomanic could simultaneously write *Oliver Twist* and *Nicholas Nickleby*, contribute sketches for Chapman and Hall, essays for the *Examiner*, edit *Bentley's Miscellany*, and be, at the same time, the author of many articles. When he was "resting" in the country while writing *Martin Chuzzlewit*, he would go for walks covering twenty miles, and the hypomania would not let him slacken his pace. His latest biographer, Pearson, gives Dickens' activities during one period in these words: "We find him organizing dinner parties, visiting prisons, applying for subscriptions to help the children of an actor, advising authors about their writings,

taking a keen interest in the management of a Ragged School, and entering into a correspondence with the district surveyor concerning a smoking chimney in his Devonshire Terrace House."⁸⁶

On one occasion (among numerous ones) Dickens was to be sports master of a dinner party. Jane Carlyle, wife of the author of *Sartor Resartus*, reports: "He had brought a conjurer's entire stock-in-trade, and spent many evenings alone in his room practicing how to make matches disappear in one place and appear in another, how to effect the transfer of money from this pocket to that, how to burn handkerchiefs and renovate them with the touch of a magic wand."⁸⁷ And so it was with all else. Leigh Hunt, who met Dickens on one such party, said of him, "What a face is his to meet in a drawing room! It has the life and soul of fifty human beings;"⁸⁸ but Charles Dickens, indeed, outdid not fifty human beings, but many times that number. Another biographer yet describes him as "laughing more heartily, weeping more tearfully, reacting more quickly than other people to all forms of stimuli."⁸⁹ To this, one should add: provided those people were not geniuses with hypomania.

In 1856 Dickens spent even more time on Collins' play, *The Frozen Deep*, than he did on *Little Dorritt*. Here again we see the great hypomaniac engaged in two serious projects: acting and writing; but for him acting was more important than writing. It was a release from the supercharge of energy and activity; only by complete exhaustion was he able to relax. Many times he had to be helped to his dressing room after he finished acting his story characters.

Being as he was chronically supercharged with energy and activity, he could, by depicting the little differences in the two Wellers, and even by his overdrawn pathos and the humorous sketches of Dick Swiveller in *The Old Curiosity Shop*, make us see these people in an eternally interesting and new light. He did

as much in his writings to eradicate the garrulous, know-it-all, busy-body nurse, Mrs. Gamp, and to abolish the imprisonment of good and honest people who simply were at times unable to pay their debts, as the author of *Uncle Tom's Cabin* did to awaken the consciousness of the American in pre-abolition days.

The hypomania, that quick mental response to everything, made Dickens also a great humorist. He was a great literary event, creator of a literature with a hue all its own, just as Tchaikovsky created music with a hue all its own. By giving us "so radiant a fairyland of fools,"⁹⁰ he made the wise people think "how much more alike we are than different," and that wisdom alone does not constitute happiness. Kipling's verse, "Judy O'Grady and the Colonel's Lady are sisters under the skin," expresses this thought better.

Many, indeed, are the cases where a writer was in trouble with his publisher, to mention only Emile Zola, Oscar Wilde, Honoré Balzac, and George Bernard Shaw; but "scully-headed vultures" were the words with which Dickens referred repeatedly to each of his publishers, bar none. This becomes more significant when one recalls that George Hogarth, one of the chief stock-holders of the *Morning Chronicle*, for whom Dickens was writing sketches under the pen-name of "Boz," had voluntarily paid him more for his articles than Dickens had ever expected.

Charles Dickens was conscious of a mysterious power within him, although he did not know that it was the power of hypomania. In a letter to a friend, he writes, "If you had seen Macready (one of the best-known actors of the day) last night (the night of the reading of *The Chimes*), undisguised by sobbing and crying on the sofa as I read, you would have felt as I did what a thing it is to have power."⁹¹ And Dickens had that power. He, more than any other living person, made Christmas day and the holiday season a time of festivity. His description of the Yuletide is worth recording: "Such dinings, such dancing, such con-

jurings, such kissing-out of old years and kissing-in of new ones, never took place in these parts before I broke out like a mad-man."⁹² Notice again "never" and the plural "ones." What is it if not hypomania in action?

I. His Periods of Inactivity and Depression

Prolonged periods of hyperactivity were bound to result in depression and creative inactivity. This is exactly what occurred in 1849. For more than a year, Dickens was in a state of depression. His mind was revolving around the idea of a Christmas book, but for more than twelve months he was so befogged that he could not visualize a single character or scene, or even a semblance of a plot. There was only a sort of obsession — to write a book which would strike a "great blow for the poor."⁹³ "Round and round it goes, and where it stops, nobody knows" might well be applied to Dickens' mental state during that period. Then suddenly a spark! — a phrase of Falstaff's: "We have heard the chimes at midnight, Master Shallow."⁹⁴ As was the case with Beethoven and Tchaikovsky, the spark burst into flame. Thus *The Chimes* was begotten. A difficult period of gestation followed; in the words of Pearson again, "He finished *The Chimes* on November 3, weeping profusely, 'All my affections and passions got twined and knotted up in it.'"⁹⁵ The author of *Nicholas Nickleby* describes his own mental state in these words: "I never can write with effect . . . until I get myself steamed up, or until I have become so excited with my subject that I cannot leave off."⁹⁶

There is no one symptom universally present in every patient, but Dickens had the "weeping Leo" Tolstoy syndrome, the Tchaikovsky weeping syndrome, and he was as erratic and impulsive as Beethoven. His intimate friends and his biographers repeat over and over again that he wept profusely. Properly analyzed, he was not, if one may be pardoned for the expression, "down in the mouth." They refer to Dickens' worries as either private wor-

ries, business worries, low spirits, or plain worries. They mean only one thing: pathologic depression. As was pointed out in the case of Tchaikovsky, depression occurs often at a time when everything seems rosy in the life of the sufferer. Dickens was no exception; dating from the appearance of Sam Weller, he became a literary might — almost a universal power admired by millions and treated with the same respect as if he were the prime minister or the king himself. Certainly he was free from any financial embarrassment. He worried because he suffered from a mental depression, the cause of which is, as was pointed out, as yet unknown.

Whoever coined the phrase “to make a mountain out of a molehill” must have observed a manic-depressive in action. At the age of 29, Dickens said, “I am expecting every day to be grey, and have very nearly persuaded myself that I am gouty.”⁹⁷ The future of his family was beginning to worry him seriously; he became anxious about their security — wanted to give them security — as if they were in immediate danger of being left without a roof over their heads or money enough to procure a meal — a typical manifestation of mania-depression. He said, “I have made up my mind (with God’s leave) to go to America — and to start as soon after Christmas as it will be safe to go.”⁹⁸

In one of his letters, Dickens described himself as a “gentleman with rather long hair and no neckcloth, who writes and grins *as if he thought he was funny indeed*.”⁹⁹ I underline this phrase because it is a lapsus lingua, implying, “I, myself, am very sad and depressed.” A hundred years ago, sadness like Charles Dickens’ could be cured by breaking up his pattern of brain activity by more hard work. Dickens was his own physician, and administered to himself respectable doses of harder work yet. This therapeutic approach is akin to what psychiatry is doing with modern shock treatment. In genius, these “shock convulsions” do not cease after the average thirty-five seconds of alternating con-

traction and relaxation of the body musculature — the intellect goes into a state of prolonged and continuous hyperactivity leading to either hypomania or depression.

Dickens had more than one period of prolonged depression. In 1854, he was creatively inactive for several months. No description of his mental state at that time is more illuminating than his own: "I am going off — I don't know where or how far — to ponder about I do not know what." ¹⁰⁰

Following his formal separation from his wife, Dickens sank into a reactive depression which lasted about two years. At times he was better; at other times he was worse, but never was he himself — hypomanic. One student of his life in that day said, "Dickens certainly was not at his best for a year or two . . . he had an inflamed mental condition." ¹⁰¹ He quarreled with everyone who disagreed with his delusional idea of persecution that the whole world — his reading public, which constituted a world of millions — had turned against him. They were influenced by two arch leaders of the conspiracy: his wife, Kate, and her father, Hogarth. Dickens' grievance read, in part: "Two leading persons, who should have spoken very differently of me in consideration of earned respect and gratitude . . ." ¹⁰² He goes on to explain that there is nothing unethical between him and his wife's sister, Georgina. The latter had the final say in everything pertaining to household management, made dinner engagements, and was his literary counselor — as much as anybody could counsel with the creator of *The Bleak House*. He does not refer to her by name because, as he said, "I honour her too much . . . and there is not on this earth a more virtuous and spotless creature." ¹⁰³ This is a slip of his tongue-soul; it justifies his biographer, Pearson's fourth adjective, "vain, reckless, egotistical, and generous." He concocted a lengthy document, naming it *Address*, which told his story — a miniature of Emile Zola's *J'accuse*. He insisted that his friends and the whole world should read it. In his calmer

moments, Dickens said, "I am quite sure that Mrs. Dickens, having received this assurance from me, must now believe it, in the respect I know her to have for me, and in the perfect confidence I know her in her better moments to repose in my truthfulness." ¹⁰⁴ The *Address* to the press is not quite a delusion of grandeur; it certainly is an "expansive delusion" — a beautiful offspring of a hypomanic mind.

J. His Creativeness

During the hypomanic drive there is a terrific output of energy; the individual grabs everything it encounters — physical objects as well as thoughts occur with such rapidity that there seems no rhyme or reason to them. But genius is capable of converting these dots and disconnected segments of thoughts into something phenomenal and beautiful — Beethoven into a Ninth Symphony, Tchaikovsky into an Andante Cantabile, Tolstoy into an *Anna Karenina*; and Dickens with Dickensonian power grips our emotions. As John Macy puts it, "With one page he can make you double up with laughter, and he can make you wet the next page with honest tears." ¹⁰⁵ Out of those dots he creates unforgettable characters. Exaggerated personalities? Yes. Horrible figures? Yes. Humorous personalities, pathetic spectacles? Yes. But all are living, feeling and heart-throbbing human beings. None of his numerous patterns of life is a fictitious, ethereal caricature, although he did utilize the element of caricature in his writings to a considerable degree. His great genius is his ability to take a hint from a human being, be it a grimace, a gesture, an exclamation or a sigh, and create a Sam Weller, a Pecksniff, a Snodgrass, a Swiviller, a Podsnap, a Cuttle, and last but not least, a Little Nell, to say nothing of the many others. Dickens did that very something over and over again. The paradox of his greatness is that his types are so much alike and yet so much different as alike, and as different as a violin concerto played by Fritz Kreis-

ler and by Jascha Heifitz. The first four installments of *Pickwick Papers* were little more than literary stillbirths until Sam Weller, the bootblack, appeared. Then "every word Dickens wrote," to use a borrowed expression, "was as if by a magic wand, converted into gold." ¹⁰⁶

English novelist Angela Thirkell, author of fifteen novels, who is about to publish her sixteenth in the U. S., was asked during a recent visit here who, in her opinion, are the two greatest English authors. Her quick reply was, "Dickens and Thackeray, I suppose." ¹⁰⁷ Indeed, Charles Dickens still ranks first in the English novel, as Shakespeare ranks first in the realm of world drama. The creator of *A Christmas Carol* is as yet unsurpassed. Many critics still decry that all of his works are "overburdened with verbal ornament;" and, indeed, that is true — but to blame Dickens for that is like reproaching a consumptive for emitting unpleasant sounds when coughing. The "verbal ornament" was hypomania in action. The ordinary hypomaniac in a psychiatric hospital adorns himself with everything that comes within his reach, and during this process of adornment, there is an incessant flow of ideas. But Charles Dickens was a genius; hence, none of his verbal adornments disfigure his unforgettable characters.

K. Biographers Either for or Against Him

Seventy-five years after Dickens was laid to rest, his latest biographer, who was *for* him, as one reviewer puts it (as yet, there are only two kinds of Dickens biographer — those *for* and those *against* him), characterized him as a "vain, reckless, egotistical, and generous man." ¹⁰⁸ All these he was — and much more. G. K. Chesterton, author of *The Life of Dickens* speaks of his "vanity, egotism, and vulgarity," ¹⁰⁹ because in one book he would write five different stories, have five different characters in five different styles. This is typically Dickensonian, which medically speaking, is synonymous with the typical Dickens hypomania.

In the case of the author of *Barnaby Rudge*, psychiatry must accept the unorthodox diagnosis of a layman that Dickens died of popularity. He was extremely popular because he was hypomanic, and he was hypomanic because he was popular. This is a so-called reversible reaction. Another student of his life says that he was a "tiresome person to have any dealings with," and that "the gap between his private character and his literary personality was even wider than it is in the case of most writers."¹¹⁰ Here again is the inexhaustible drive of hypomania that made that gap wider yet. The stimulus of acting his characters drove him persistently to more and more work; finally it resulted in his premature death at the age of fifty-eight.

L. His Sudden Death

On June 8, 1870, the great actor and writer was sitting during the dinner hour at the head of the table in his mansion, Gads Hill. There everything and everyone had to be punctual and proper at the table. And they were — all but the master of the house! Within the soul of the great hypomanic a terrific struggle to hang on for at least an hour was taking place. Dickens had had a foreboding of oncoming disaster. He tried desperately to conceal his antemortem pain from Georgina, but his haggard and tormented appearance betrayed him. His intuitive worshipper, Georgina, sensed it, and asked him whether there was something wrong. He answered simply, "Proceed with the meal." His courage continued almost to the last dish of the sumptuous dinner — then he collapsed. He tried to tell Georgina something but his speech became unintelligible. The only words he was able to pronounce clearly were, "I must leave for London" — for a Londoner Dickens indeed was! If Georgina had not interrupted his fall, he would have hit the floor violently. Then three more words: . . . "on the ground;" these three short words are symbolic, indeed, of him who was so much of the time "up in the air." Could he have

spoken, he would have said, "At long last I am glad to rest . . . on the ground. . . !"

In twenty-four hours he was dead, without having regained consciousness or having uttered another syllable. He was buried at Westminster Abbey in the Poet's Corner — and, indeed, great poet, at least of the poor and down-trodden, he was!

A glimpse into Dickens last will and testament reveals further the beauty of his soul. He commends his soul to God and to the mercy of Jesus Christ, and his works to the judgment of posterity. How much like Beethoven, whose models were Socrates and Christ! Posterity lives Dickens' characters and follows them to the very end, very much as their creator did until he wrote on them the last word, "Finis."

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Chapter XVI

SCHIZOPHRENIA

By EDWARD W. LAZELL, M.D., Psychiatrist

Veteran's Administration, Denver, Colorado

In a Discussion of Thinking and Feeling

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I. A Dissociation of Thinking and Feeling

Schizophrenia is the term now applied to the largest and most important mental syndrome. The term itself should be studied because it evolved with the gradual understanding of this malignant condition. The syndrome portrays the failure of the individual to develop that harmony of thought and emotion which would be consistent with his place in society, and the resulting disorganization of personality, with feelings inappropriate to the moment consciousness, dilapidated thought and behavior wholly unadapted to his personal and social need. Economically, schizophrenia is outstanding since, under one or another name, these persons constitute over sixty percent of the mentally maladapted.

The clinical picture of schizophrenia has been known for a hundred years. Some of the early writers gave very accurate descriptions of a mental state in young persons which emphasized the disorganization and inadaptability, phases which later were neglected in the intimate study of the psychology and the search for the cause of the syndrome. These descriptions and their variations were continued until Kraepelin united the catatonia described by Kahlbaum in 1868, the hebephrenia of Hecker (1870)

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and certain paranoid psychoses under the term *dementia praecox*. Kraepelin believed that the clinical symptoms and deteriorating course lead to true dementia.

Kraepelin's belief that *dementia praecox* occurs only in the young and that the outcome is dementia has been abandoned. His other teaching, that the symptoms are probably due to a metabolic disorder or to an endogenous toxin greatly stimulated research in that direction. This resulted in grouping as *dementia praecox* all of those mental states where disorders of thinking and feeling were the outstanding symptoms, lead to disorganization of the personality and made the patient unable to adapt himself to the demands of his social environment.

Interest in the Kraepelinian classification of *dementia praecox* lead to careful study of the symptoms and showed that one of the most important is the dissociation of thinking and feeling characteristic of the age level of the patient. In the extreme degrees of this dissociation the patient often had an intellectual capacity far beyond his years combined with the emotional life of a child. It was this characteristic that lead to the term schizophrenia which means a splitting of the mind.

In the meantime the Freudian psychology stimulated the study of the mental mechanisms which had proved to be handy concepts for the analysis of the symptoms and correct explanations of their dynamics. It stimulated the study, from many points of view, of the symptomatology of what is now called schizophrenia.

II. The Course of Schizophrenia

A. General Symptoms

The underlying personality structure of schizophrenia is either slowly developing or else slowly regressing. The behavior of the individual is, however, largely determined by his present personal affective needs which are often encroached upon by the demands of society, so that this underlying structure may be suddenly and

profoundly influenced. Acute and unexpected emotional outbursts may occur when the metabolism is altered from within. These changes occur especially in the severe biological adjustments following infections and the diseases of childhood, and when one endocrine epoch merges into another, as in the endocrine changes of puberty, marriage or childbirth, on the one hand; and from social calamities such as the loss of parents or loved ones, the stress of war or school, or insolvable conflict with the parents or their representatives, on the other.

The schizophrenic reaction may be described in general terms as a group of psychotic disorders showing disturbances of the patient's relation to reality and his ability to form normal concepts; disharmony of thought and personality disorganization result. The symptoms are flight from reality, emotional disharmony, and inappropriate and unpredictable disturbances of logical thought. In the early stages the disturbances of reality are largely in the patient's relationship to himself; after regression occurs the disturbances are mostly in connection with outside reality and concern the elements of time and space. In some cases, mild deterioration occurs. This is more marked in the cases showing regression.

The mental development of the individual starts no later than at birth, and the symptoms which lead to schizophrenia are usually seen in childhood. These early symptoms are rarely those of a frank psychosis which usually results from the pressure of reality operating in a biologically vulnerable person. Definite symptoms are, however, commonly seen in childhood and have been defined as a type of personality which is given different names according to the school of psychology of the observer. The simplest of these is the "shut-in" personality, and loosely described as showing seclusiveness and diminished interest in outside reality with a resultant physical inactivity; lessened emotional tone which leads to disturbances of affective contact with

reality, especially with other persons; introspection and egocentricity followed by increased sensitivity to criticism and the force of reality; a defensive attitude shown by negativism; and a reversion to a more primitive form of behavior shown in mannerisms, bizarre speaking and thinking. In the more severe forms this bizarreness merges into the grotesque and, finally, into silly, senseless and wholly disorganized thought and action. This bizarreness and silly, senseless, disorganized thought and action is, however, the interpretation of the beholder at the adult reality level. To the patient the grotesqueness, dereistic thinking in symbols which resembles the dream state, centers in and around his ideas and fears of being dominated or persecuted. They portray his feeling of compensatory greatness or grandiosity, and contain his feeling of sex. These delusions are never meaningless to the schizophrenic. On the contrary, they always describe his conflicts perfectly.

B. The Sensitive and Anaesthetic Types

The description of the schizothymic personality of Kretschmer and the schizoid temperament of Bleuler include most of the important personality abnormalities. Both emphasize the inappropriateness of the emotional life and the poorly socialized personality, characteristics which make them regarded as "queer" by their playmates in childhood. There are two types; first, the sensitive schizoid reacting toward the environment with an increased irritability, and second, the anaesthetic type of schizoid who regards the environment with an apparent indifference.

Persons of the sensitive type have never been in tune with the environment and consequently feel lonely and isolated. Repeated failure to adjust has made them timid and shy, self-conscious and dissatisfied; but the inherent demands for social equality or superiority has lead to stubbornness, a holding to their own point of view with remarkable tenacity despite every effort to show

them why they have failed. They refuse to admit the possibility of the failure being in them and resent the refusal of society to change its ways. Self-love is so acute with them that their feelings are easily hurt; misjudging the motives of others, they feel that they are not understood and become suspicious of everyone.

The striving for social security and their failure to achieve it by contact with their fellow-man often leads to superiority in school work so that books become substitutes for human companionship. In them they find the impersonal hero whom they can emulate (in their day dreams) and still avoid painful human contacts. They gradually choose the abstract subjects, such as philosophy or nature studies, in order to avoid competition with others on a personal level such as would occur in the sports or in debates.

Ambition to gain perfection haunts them and makes them over-conscious and meticulous, avoiding the coarse and vulgar on every level; but their circumscribed emotional life limits the elasticity of their initiative and love of variation so that their efforts become more and more a simple pattern, repeatedly the same, and unproductive of real progress and satisfaction.

Turning their interests within themselves, their imagination supplants directed thinking on the plane of human motives at the symbolic level so that they avoid as much as possible all contacts with painful reality. They build a wall made of the repression of emotional contacts with human beings and retire behind it to a world of phantasy where wish-fulfillment thinking is the rule.

Those of the anaesthetic type of schizoid also work out emotional problems in their imaginary experiences which lack the finer emotions. The poverty of esthetic qualities is shown by neglect of their personal appearance, their indifference to the home, and especially by lack of politeness and consideration in their intimate contact with other members of the family. Some are kind and honest but emotionally dull and asocial. Lack of

spontaneity makes others appear indifferent, indolent and colorless. Those who are cold and reserved in adolescence are usually very wilful and ill-tempered, easily offended and disobedient to an unbelievable degree. Some shrink into themselves and become preoccupied with day-dreams in which they work out their hatred and revenge on their parents and siblings, and more successful acquaintances. Their over-confidence in self is a compensation for their feeling of insecurity and usually betrays the underlying destructive emotion. As their experiences with life unfold they become more and more embittered and assume a moral idealism with rigid rules of conduct and a self-satisfied intolerance of others. The outstanding features are an uncompromising inflexibility and negativistic attitude combined with a resentful hatred of advice and supervision, which makes correction by ordinary social agencies quite impossible.

III. Acute and Chronic Schizophrenia

A. Onset Difficult to Determine

There are two large groups of schizophrenics:- the acute and the chronic.

In many cases of schizophrenia it is difficult to determine when the onset of the psychosis occurred, when the schizoid personality merged into actual, irreversible changes which were definitely psychotic. This is especially true when it is recognized that the schizophrenic reaction may be present for a long time before it is suspected, and that a borderline adjustment is often present for years without developing into an overt psychosis. The schizophrenic reaction is then said to be larval, latent, incipient or borderline, and is usually discovered only through special tests.

These incipient or borderline cases show schizophrenic actions and methods of thinking such as peculiar mannerisms and sudden, impulsive acts which are apparently not logically motivated. Their friends regard them as only eccentric, peculiar, or queer;

but when these persons are deeply studied with the means available in a well-equipped psychological laboratory, definite disturbances of thinking are often found, and of such severity as to justify the diagnosis of psychotic. It is of the utmost importance to recognize these cases and to treat them early.

B. Acute Schizophrenia

The acute type of schizophrenia is very important for study. In it the patient is overwhelmed with his symptoms which progress so rapidly that he is not able to form many adjustments to them. They are, therefore, more often in pure form. The ego shows less defense against them and the projection mechanisms are less systematized. The onset is usually sudden after a crushing contact with reality which may not be apparent to the onlooker but which to the patient was a calamity. This is because the force of the fear element contained depends upon the integration of that fear during development, and integration varies with the individual. The symptoms occur in somewhat the following order: Emotional hyperactivity, confusion in thinking, partial disorientation, introspection in an attempt at orientation but with failure, unsystematized projection with ideas of reference and ego humiliation, mild dissociation with transient recognition of fear followed by excessive phantasy and dream-like states, depression often associated with auditory hallucinations, ideas of death and a feeling of impending death, panic often with the acceptance of the death wish, contemplated suicide often with an overt act, severe disturbance of external reality relationships with loss of correct evaluation of space concepts and more or less complete dissociation and amnesia. Recovery from these acute symptoms may occur on removal of the patient from the causative environment. The outlook depends very much on the amount and degree of *somatic* regression which has occurred.

The following short abstract gives the salient details in the

development of an acute schizophrenia of the paranoid type:

Patient is a 31 year old white male. Father had asthma and hypertension. The mother, nervous all her life, had a cerebral hemorrhage at 60. Grandfather was alcoholic and the mother's relatives very superstitious. The mother, herself, believed in witchcraft, re-incarnation, and hexing. The family finances were poor.

At nine the patient had pulmonary tuberculosis and was confined to bed for nine months; bit his nails until 14; broke several bones playing football. He had one year of college after which, he drove a truck and was an apprentice to two trades; did not get along with anybody, made a poor economic adjustment; smoked marihuana at 16 and later drank to excess.

The psychosexual development is important. At 9 had his first sexual relations with a girl who was 14 years old and the aggressor. He continued similar affairs with aggressive women, but was never satisfied, felt that there was something missing. Planned to marry one of these girls but did not succeed with himself.

Lost interest in women, developed worry, irritability, tension, insomnia and apprehensive dreams. Indulged in cunnilingus and pederasty and, when first seen, complained of headaches and feared that he was becoming homosexual. Found it increasingly difficult to resist his homosexual craving. During the two years when he was projecting this desire, he had felt that he was misunderstood, unfairly treated, that people in general were watching and talking about him. He heard accusatory voices calling him vile names and felt that "they" were discriminating against him. His paranoid trends were shown by his ideas of persecution and reference, and the feeling that people thought him queer. His acute psychotic symptoms were developed to prevent his homosexual craving.

ings from becoming conscious and the anxiety neurosis was caused by the fear of death. The diagnosis was psychoneurosis in a constitutional psychopathic state.

Depression with self-destructive ideas developed somewhat later. He felt unable to succeed, that people were still against him and were treating him unfairly. He disliked strangers and admitted having auditory hallucinations of music.

About this time a definite change of personality was noticed. He became impatient, procrastinated, lost his enthusiasm for everything. He could not hold a job or meet people. He became wholly impotent with his wife, could not go out socially at night, felt inferior, inadequate and sank into a lethargic state marked by depression and hopelessness.

The sequence of events seems clear: A heavily predisposed individual who, in childhood, was surrounded by superstition and lacked the inspiration of a strong father, developed asthma and was integrated in a benign, submissive sexual role. In the service, there was a wide diversity of stimulating and repressing forces. His highly developed homosexuality found an overt outlet, but the fear of exposure and "the fear of becoming homosexual" repressed this craving. He developed the typical paranoid triad: Systematized ideas of persecution, auditory hallucinations, and oral sensory disturbance which found overt expression in cunnilingus. As often happens, the attitude of the ego changed toward the uncontrollable homosexual cravings. When the paranoid recovers quickly, it is usual to find that he has been assisted by someone; in this case, by the dominant heterosexuality of the other soldiers in training. The official army regime was essentially heterosexual and curative. The fear of death initiated a panic in which the dissociated homosexual cravings precipitated an acute overt exacerbation of the para-

noid situation while the repression of the anxiety emerged as an anxiety neurosis.

The physical symptoms now became prominent. Fear associated with the self-preservative instinct exhausted the kinetic system and left him depressed and self-destructive. Libido changes followed this exhaustion and were shown as a general let-down. He married hoping to recover his early eroticism but the ego had lost its force with a resulting heterosexual impotency, a feeling of inferiority and inadequacy, and marked withdrawal from social contacts and an ominous outlook.

C. The Chronic Types

1. Simple Schizophrenia

Cases of chronic *simple* schizophrenia show essential defects of interest with gradual development of an apathetic state. There is no other strikingly peculiar behavior and no delusions or hallucinations. The early symptoms are unsociability, seclusiveness, serious-mindedness, often with nomadism and eccentricity. Lack of interest in the external environment leads to a lessened store of human relationships. Many adjustments must be made on the lower psychobiological levels and the physical symptoms are often prominent. These include fatigue, depression, toxæmias, shock, apathy and psychomotor retardation. Over long periods of time the symptoms do not change except to increase in severity.

The following abstract of a case of chronic simple schizophrenia illustrates these points:

A 34 year old white male. Mother died of diabetes, high blood pressure, and kidney trouble when the patient was 8. A brother was hospitalized for a nervous breakdown. Patient suffered from fear of the dark, of being left alone and of water since childhood. Was always shy and seclusive. Enur-

etic until 7. Said the girls did not like him, and so he never went with them. Completed the 9th grade at 15. Wandered away and lived with a foreign population for nearly a year. When found, he was apathetic, listless, unable to see anything unusual in his actions. Was given insulin shock therapy, 24 doses with 20 shock reactions but remained apathetic and listless, unable to concentrate. Said that he had had a nervous breakdown, started to have tremor, anorexia, nightmares, insomnia, and fatigue. Thought that his bosses picked on him. Suffered from many periods of depression and often wept.

Despite all treatment he remained apathetic, listless, preoccupied, confused, seclusive, rigid, at times inaccessible. Psychomotor activity decreased. Stream of talk was slow, hesitant, monotonous with some blocking. There was extreme flattening of affect. Thought processes were loose, vague, and abstract. Ideas of reference and persecution were absent. Hallucinations and delusions were denied. Sensorium was essentially clear. Judgment was impaired, insight lacking. He was neither suicidal nor homicidal. There were feelings of inferiority and inadequacy. The early diagnosis was psychoneurosis, anxiety type, severe.

He continued, however, to have symptoms of severe anxiety, tremor, intestinal indigestion, fatigue, sweating of the hands and feet and startle reaction. He laughed in a silly manner and the laugh was inappropriate. He remained simple, flat, unemotional, seclusive and withdrawn but had no ideas of persecution or hallucinations. He said he felt inadequate and had difficulty in concentrating.

As time went on these symptoms increased in severity so that he was more and more seclusive and withdrawn. As his emotional life flattened, the silliness and inappropriateness increased, and regressive features appeared at the anal erotic level.

2. The Chronic Hebephrenic Type

In the chronic hebephrenic type the affect is shallow and inappropriate, with a predominant tendency to silly and manneristic behavior. The smiling and laughter are wholly inconsistent with the ideas expressed, and often interrupted by giggling and talking to himself. The speech contains peculiar and bizarre ideas, such as coined words and phrases. Auditory hallucinations are the rule, the voice heard often being ascribed to the mother or to God. The content of the hallucinations may be very disturbing, such as vile names, curses or accusations; but pleasing hallucinations are equally prominent. During the course of the psychosis there may be delirium, apprehensive states or panic with loss of self-control, and delusions of a somatic nature. In the later stages, the patient is usually disoriented and his phantasies of gratification of his cravings at the infantile level, indicating the degree of regression. The following is an abstract of such a case:

Patient is 41 year old white male whose father died in an asylum. The step-father was cruel and the patient was always in conflict with him. Later the mother was eccentric, confined in an institution and taken out by the patient, although she was mentally incompetent. He was one of six children, enuretic until 9, had temper tantrums, talked in his sleep. Went to school intermittently, had the equivalent of three years education, ran away from home at 11, tried to get along selling newspapers but was placed in a state home for dependent children. He joined the army, deserted, was court-martialed and served a year in prison. Following this, he was drafted, married a sixteen year old girl at 26. The marriage lasted three years.

He was honorably discharged with a diagnosis of "dissociative reaction, severe, acute, manifested by confusion,

disorientation, retardation and depression." When hospitalized he said that he was "floating on the air as though he could run and not get tired." He was passive, retiring and unaggressive; eloped from the hospital wearing pajamas, coat, hat, and shoes. Said he had started to the draft board to re-enlist. Was confused, developed inappropriate affect, became silly, barked like a dog while walking on all fours, laughed to himself.

When he was examined later, he was depressed, admitted hallucinations in the past and showed poor memory; was introspective and self-centered. Found it difficult to concentrate, frequently lapsed into day-dreams and was monosyllabic. The electroencephalogram was normal; the Rorschach showed dissociation and intellectual and emotional confusion with flight from reality and depersonalization. The Wechsler gave him an IQ of 91 and indicated a deterioration of 24 per cent.

He was examined at a still later date and said that he was not employed but that he worked as an accommodation to other people and that they thought he was a fool. He was correctly oriented, showed poor ability to multiply and subtract simple numbers and an inadequate knowledge of current events, admitted that there was a time when he was hallucinated, hearing mumbling noises and people laughing at him. He planned to get married after his mother passed away and he had a house to live in. He often dreamed that his mother was dead and volunteered the information that he often had day-dreams of fighting someone and was always winning the fight. Said his mother was part Indian. When an effort was made to determine what tribe she was from, he said that the tribe was the "Carter Indians," a group named after a man by that name. He thought of the father, on the other hand, as a very great man, very intelligent and very wealthy. He

thought that this must be so because he had so many aristocratic ideas about himself. The whole projection was obviously a part of his neurotic family romance.

The analysis of hebephrenic dementia praecox shows that it is a flight from reality into a definite type of delusional state, with reactivation of infantile love and fear integrated with the primitive instincts. The patient goes back in his fantasy life (regresses) and lives over again many experiences which resulted in these integrations. There is complete abandon to an incessant stream of thought, the content of which is his infantile motives.

The field of consciousness is contracted, dissociation takes place and the infantile ego replaces the pseudo-adult. The patient lives emotionally in the past, and not in the present. He feels like a child again. This has been accomplished by a retrograde regression, which will be described later. As a result of it, however, there is an abnormal state of consciousness, a developmental temperament which is continuous, permanent and characteristic, best described as a retarded or undeveloped adult character.

Examination of many cases shows that there were conflicts in the home, school, business, social, and married life which ranged beyond the normal and led to the development of the self-regarding or ego-complex. The real adult level was never reached and the creative energy found expression at the level of aggressive homo-eroticism. Seventy three per cent of the inmates remained single and there was a feminine endocrine tropism (adrenal, thyroid, and posterior pituitary). Only 20 per cent ever had any heterosexual impulses.

Fear of inferiority and inadequacy made the patients hesitate to go into the world in active competition; fear of self was structuralized into a habit and showed in all of their reactions. There was no adequate solution of the problems of the creative energy in any of its phases, nor of the will to power, nor of the correction and domination of their inferiorities. They had never

freed themselves from the identification of the ego with the subconscious images of personality. The pseudo-adult personality was an attempt to adjust to reality, but the subconscious continuously obtruded its infantile motives through this thin layer, broke down repressions, influenced conduct, and limited their capacities.

3. The Chronic Catatonic Type

The chronic catatonic type of reaction is characterized by the prominence of a motor behavior which occurs in two opposite phases: One marked by generalized inhibitions, the other by motor excitement. The inhibitions are expressed in negativism, standing in one place motionless for days or weeks at a time if permitted, waxy flexibility, stereotyped behavior and hallucinations, stupor and mutism. Such cases often have to be fed with a nasal tube for months at a time. The opposite phase is marked by excessive motor excitement and impulsive actions. When the patient comes out of his stupor it is found that his sensorium has been clear. These changes often occur in short cycles or from four to six weeks and cases with these cycles are more likely to improve and to go into remission than those that do not have them. Others often regress to a state of severe vegetative existence. Recurrence of the major episodes after an interval of remission is frequent. The following abstract illustrates one of these major episodes in a catatonic of many years duration:

Patient is a white female of 41 years. The father died of a kidney condition and the mother of heart disease. Two maternal uncles died of cancer and hyperthyroidism, while polyglandular disturbances were noted in several collateral members of the preceding generation. The patient, herself, had always had a bad disposition and had shown temper tantrums and excited periods all her life. She graduated from high school and was an excellent student. Two of her children had had poliomyelitis.

The history showed that she had had an episode of stupor about four years prior to the present admission. During that attack, which lasted for several weeks and which was diagnosed as acute encephalitis, she did not recognize the members of her family; following it she was not acute mentally as she had been before, had some difficulty in finding the right word and showed a change in her handwriting.

During the interval she had become progressively less able to cope with her household duties and had shown definite personalities changes. The precipitating stress of the second attack was apparently the impending visit of a brother. She reacted by excitement during which she insisted on leaving open the doors in cold weather so that the brother could come in, accused the neighbors of wholly unfounded actions and finally locked herself in her bathroom where she was resistive and combative, making it necessary for her to go to a hospital.

In the hospital, she alternated between crying and singing, was hard to keep in bed, refused food, was noisy and combative, destroyed the bedding and was exceedingly agitated, growing more and more unintelligible. Among her productions was the statement that God knew, and writing a letter to the authorities about an unsolved murder. She was distrustful, suspicious and told of many imaginary things that had come to pass.

Electric shock therapy had a very favorable influence so that she partook of food immediately after. When the influence wore off during the afternoon, she again lapsed into her excited state, throwing her arms around and becoming very agitated. There was, however, some improvement from day to day so that she accepted the ward routine. Insulin treatment was substituted and recovery from the episode followed.

Another patient observed by the writer had sat on the ward bench in his pajamas and slippers for several months. During that time, he had not spoken a single word nor voluntarily lifted a hand or even an eyebrow. He had been absolutely motionless and there was even some question whether or not he ever closed his eyelids. He had been artificially fed, put to bed and dressed, bathed and cared for like a baby.

An unusually powerful mentally defective patient had removed enough of the protective screening to permit a body to pass through and induced the catatonic patient to leave the ward with him. Together they made their way in their pajamas, slippers, coats, and caps (which the defective patient had secreted) over six inches of snow on a very cold night to a railroad water tank a mile away, boarded a freight train and were apprehended the next morning in a metropolitan city several hundred miles from their starting point.

They were returned to the hospital the next day unharmed, and did not even catch cold. After being returned to the ward, the patient sat for the next six months (when permitted) motionless, speechless, every want being supplied by the attendants.

Another patient had been mute for months. Since coming to the hospital he had spoken only one word: "Cincinnati." On February 7, 1927, he was asked the date and how he was getting along and replied: "I do not know, doctor." He was asked what was wrong with him and replied "I am dead. I was killed by a woman. That woman was my mother. She hit me on the head."

Still another patient had stood motionless unless prevented for hours at a time in a corner of the ward, his body motionless, the hands and feet blue. He was mute, tube-fed and required constant attention. When first admitted, he had shown extreme waxy flexibility.

These cases are recorded in the files of years ago. Thanks to modern methods of treatment, such cases are rare at this time.

4. The Chronic Paranoid Type

In the chronic paranoid type the reaction to the environment is almost constantly one of anger and hatred, hostility and aggression. The behavior is unpredictable. In the early stages the patient reacts to his hallucinations which occur in several fields; but later he may become indifferent toward them as deterioration sets in.

Thinking is of the schizoid, unreality type. The mental content varies as the paranoid quality increases. In the early stages there is often a characteristic predominance of delusions, especially of persecution, less often of grandeur. Sometimes the whole delusional structure is composed of an excessively religious system which is usually a personal one. In the later stages there is a grossly expansive delusional system composed of bizarre ideas proving his superiority, special capacities, genius in many fields or omnipotence. The wishful-fulfillment of these fantastic elaborations is easily seen.

The psychosexual fixation in these cases is predominantly at the homosexual level so that the homosexual component is prominent. This is in marked contrast to the other types where the psychosexual development has either not reached this level or has regressed to more infantile ones.

The following abstract illustrates these points:

Patient is a 39 year old white male. Father died of a heart condition. Patient had spinal meningitis and pneumonia at five years. Graduated from high school. Changed jobs frequently. Did not make a success of his work.

At the onset of his episode, he became confused, began to show marked fear, tremor, and hesitation in speaking, feared everyone in authority, worried for fear he would not do his work correctly. He thought people were watching him and

that someone was after him; became disoriented, confused, showed blocking of thought and was incoherent. Did not fully understand questions asked him. Became restless, tried to elope from the hospital, stammered and stuttered.

Later he became uncooperative and obstinate, suspicious and very exacting in his replies, looked about the room suspiciously to see if anyone was listening. Was seclusive and retarded. Thought that God conversed with him and told him what to do. Stood in one place for long periods of time. Believed that his thought and actions were controlled by someone else. Memory was not impaired. Judgment was defective. He feared to go out lest he become lost.

Was given insulin shock treatment and improved. Later smiled inappropriately, was evasive, inaccessible. Showed emotional leveling, was depressed, suspicious and remained aloof. Became hostile, suspicious, resentful. Denied all psychotic symptoms at any time. The diagnosis was schizophrenic reaction, paranoid type, improved.

Analysis of the flight from reality in the paranoid form is quite different from that in the hebephrenic type. In the hebephrenic type the infantile love-fear integrations of the primitive instincts are reactivated and these experiences are lived over again in the phantasy life of the dissociated state. In these delusions there is great contraction of the sense of space toward an infinity of annihilation with death at the apex. The patient feels like a child or embryo, or as if dead, due to the loss of the sense of space.

In the paranoid type the regressive feature is disguised by an eccentric compensation in which the subconscious past is projected into the future in the direction of an infinity of perfection, power, or exaltation of the ego. This is due to a great contraction of the sense of space and expansion of the sense of time. But the complete dissociation of the hebephrenic does not occur. The infantile personality displaces the adult personality in a limited

field only. The constant attempt to adjust the infantile personality to adult environment affects a compromise between the two.

IV. Schizophrenia is Not a Clinical Unity

The histories of these patients show that they were potentially paranoid before the onset of the psychosis. The ego-complex was greatly over-developed, but at the adolescent or pre-adolescent level. It had never reached the adult type. In his failure to adjust, the patient had compensated for his inadequacy by an exaltation of the ego. The creative energy had found expression in the form of submissive homo-eroticism which is a feminine endocrine tropism. The patient feels that he is a woman, submissive, homo-erotic and inferior. He is going to be influenced by someone, shot, stabbed, crucified, cut to pieces, have a leg or arm cut off. The delusion is the opposite of the subconscious feeling.

Individual mechanisms of this type appear in superstition, voodooism, fetishism and many other pseudo-religious beliefs where the good- and bad-man image (and symbols of them) are utilized as symbols.

The study of a large number of cases of schizophrenia has shown that: (1) There is no evidence to justify the belief that schizophrenia is a clinical entity in etiology, symptoms or pathology. Up to a certain point, the symptoms are reversible so that acute cases may apparently recover. In fact, the greatest variability is in the different outlook for recovery in the various types. (2) The type is usually determined by the predominant symptoms at any one time.

(3) No one symptom can be relied upon to establish the diagnosis: Schizophrenia is a syndrome and is peculiar to the individual. Even somatic regression is an uncertain criterion since it may not be present in the early stages and then appear after one or two decades.

(4) Both physical and mental symptoms are found.

(5) Dissociation of affect is the method (mechanism) by which the symptoms included as delusions and hallucinations are formed; somatic regression is responsible for the affective deterioration.

(6) If a longitudinal section of the average case is studied (from childhood to adult life) most or all of the different types will appear; that is, every case is a mixture of hebephrenic, catatonic and paranoid symptoms in varying proportions. This is due to the bisexuality of every person and to endocrine changes. The variability is due to the changes in body protoplasm from hereditary influences, diseases in childhood, the endocrine pattern and life experiences. The following abstract illustrates these points:

In individual cases unexpected and apparently inexplicable symptoms may suddenly occur, such as epileptiform convulsions (10 to 25 per cent), sudden attacks of maniacal fury with homicidal attempts or extreme depression with suicidal attempts, or periods of amnesia. On the whole, one may say that schizophrenia is a syndrome where the symptoms are specific to one individual.

A 31 year old white male had shown early symptoms of confusion, ideas of reference and influence, feelings of guilt, inadequate emotional reactions and paranoid trends. These symptoms had led to a diagnosis of schizophrenia, paranoid type. Electric shock therapy had been followed by some improvement but observation was continued because of his peculiar behavior, confusion and depression. He imagined that he had two personalities—one evil and one good. He was unable to think and could not perform his duties, said that the powers of suggestion were controlling him, felt that he was a traitor and was going to be shot. He turned against the Bible because he could not overcome his feelings of guilt, and against his friends, wishing to kill them.

He identified his wife with Hitler and himself with Hirohito and finally identified himself with Hitler also. When he

told of this he smiled and giggled in a silly manner, but he said that he was frightened. His emotional reaction was inadequate, judgment defective and insight lacking. The diagnosis of paranoid type was now doubted. During a later examination he was confused, incoherent, depressed, and cried, showed poor memory for recent events, had arguments with his friends, said he had lost the ability to think for himself, was dominated by other men's ideas, used large words without knowing their meaning, thought people were working against him behind his back, heard voices calling him vile names, thought people were listening to him and showed marked blocking of ideas. Thought that people were descended from dogs, passed through an amnesic period and would neither eat nor talk. At time, he felt partially paralyzed in the arms.

At a still late date, he was dull, apathetic, indifferent, indecisive, and flat. Psychomotor activity was depressed and while he admitted having had delusions and hallucinations in the past, he denied having them then. In the meantime, he had become very dependent upon his wife. The diagnosis was changed to schizophrenia, mixed type.

Some features of still another case diagnosed as the hebephrenic type of schizophrenia are now added because they contain so much material originating in the family romance of neurotics and also will illustrate emotional regression.

This patient had almost completely symbolized and projected his conflict so that most of his ideas must be interpreted on a symbolic level. He had a large delusional field of persecution and influence. Thought that he was endowed with an exceedingly great power, that "they" had put electricity on him to kill him and were trying to take his mind away from him. He talked with God and felt very superior; was constantly hallucinated, heard inhuman voices, at times the

voice of a bad god known as the Gila Monster, which evolved from the ape. He stated that he was chief of the North American Indians, made the Great Lakes and built the Rocky Mountains. He was the Indian's "Great Spirit" but denied that he was Christ. He said that his wife was stolen by King Ben of the House of David. He said he had been ambassador to Berlin, England, Japan, and China and spoke the language of these countries when he was abroad.

When he entered the hospital (many years ago) he had a tinea sycosis of the face which he explained by saying that his face was burned by liquid fire playing on strata in a mine in the sixteenth age, when the world was in corruption.

He projected one of his symbolic deaths upon the earth, stating that there was a collision between the earth and a comet which resulted in the atmosphere being divided into two parts. There was a disturbance of the earth with rain and volcanic eruption (symbolic birth). The powers of earth were sprayed in liquid form and everything shrank and became of smaller proportion, (negation of birth). He then added that he never was born; that he was "King Tut" and lived 3,000 years ago.

The patient recorded seven personal regressions. The number of his episodes is important since seven is the infinity of mathematical extension in the normal mind, and further important because it indicated that recovery may occur even after profound disturbances of the psyche have taken place. He described his feeling while in the regressive state as that of a child, as though all the power were leaving him. When the power came back he felt that he swelled up. Sometimes his shrinkage was only partial, as when he lost his voice. He ascribed this shrinking to the brain power of others:

The first time he shrank was when he was thrown off of the throne of Roumania. He said he was the Lost Prince and that

the queen of Roumania was then in the United States because of his trouble (Patient made this statement to the present author in 1925).

The second time he shrank he was blown to pieces on a dynamite train. The power in his body drew the pieces together again (see the myth of Isis and Osiris).

The third time he shrank was during the World War I when he was killed by X-ray.

The fourth time he shrank was when he was drowned on the Lusitania. He fought his way back to land. He was at one time known as a god from the sea. (The error in the chronological order was probably accidental but may have been motivated.)

The fifth time he shrank was during President Harding's time. "They" put the death ray on him. Both President Wilson and President Harding are constellated with his delusions of persecution and reference.

The sixth time he shrank was from heart trouble. He had forgotten the cause of the other regression, probably from some personal reason which he did not care to divulge. The analysis of this series of regressions will be apparent to the student who is familiar with the family romance of neurotics. The bizarre delusions of hebephrenic schizophrenia are largely made up of such material.

There are two mechanisms which require special discussion: first, dissociation, and second, regression.

V. Regression in Schizophrenia

A. General Regression

During times of emotional stress there is a conflict between the self-respect or ego complex and the self-preservative complex. If the fear of the environment or of self is intense, the self-preservative instinct gains complete control and the self-regarding complex

is broken down by the fear of adult activities. *There is a specific contraction of consciousness and an immediate dissolution of the pseudo-adult ego.* Adult activities cannot find representation in consciousness of this contraction. Infantile and childhood integrations of the primitive instincts have proven insufficient for the problems of adult life and the patient goes back to his childhood days to start over again the building of a sufficient adult personality. *The subconscious undeveloped personality eplaces the pseudo-adult adjustment* and he becomes a child again in his emotional life.

The mechanisms, however, are not so simple. The stages of this internal conflict include all of the fundamental problems of psychiatry. When life on the adult reality level becomes intolerable, energy is dammed up and cannot find expression. It has traversed paths of less resistance during the developmental years and to these methods of expression it readily returns. *This is the first flight, a de-differentiation of the libido.* It solves all difficulties so far as the fear of environment is concerned because the patient is removed from society and renounces the responsibility for being a social animal. He returns to the protection of his subconscious images of personality.

This flight does not solve the problems of his ego conflict. The only reason he ever left the lower level was the fear and pain associated with the gratification of this energy at the lower level. When he returns to the lower level there is a reactivation of all of the old problems connected with it. Two courses are now open: (1) To abandon himself completely to the subconscious phantasy gratification of these infantile emotions, the hebephrenic solution, or (2) To struggle against and refuse these phantasies any form of recognition, the catatonic solution. This latter negation of thought reduces him still lower in the scale, so that he has to be cared for as a child. The energy cannot find expression even in phantasy or automatic associated movements, and falls back to the

reflex level, with postural tensions and spastic tonus. This is the second stage.

The regression to the infantile age reactivates those emotions which were acceptable at that age, but which are no longer so. These motives were infantile incest, auto-erotism, or homo-eroticism. The infantile or later feelings of inferiority, guilt, shame or inadequacy are also reactivated and cause psychic pain. He tries to find a reasonable excuse for his inferiority and rationalizes it in some manner, finally projecting it on the environment. His attraction for his own femininity seizes upon any symbol for that femininity, the mother, sister or cousin, and he projects the gratification upon these symbols. These imaginary experiences are the delusions.

With reference to the specific contraction of consciousness, he may eat, dress and conduct himself on an adult level in many ways. The affects which return in their original form are the ones most regressed and always relate to the infantile, pre-adolescent or adolescent symbols of his own femininity or masculinity, his woman- or man-image. The most common symbols of the three levels are his mother or sister, his own body and a feminine male. These symbols are now the objects to which he attaches his emotional gratification in his phantasy experiences. With the reactivation of these love objects there is also reactivation of the love aim of the corresponding level, his infantile birth fantasies and his conceptions of life and death.

He does not escape the pressure of his ego-ideal in these phantasies. All repressed motives were bad motives (to him) and connected with a sense of guilt, else there could have been no need for repression. The bad motives are associated with the bad man- or woman-image; and the good influence of the ego-ideal with the good man- or woman-image. *There is, therefore, a splitting of phantasy or subconscious activities between these two influences.* Schizophrenics describe the dual conditions brought about by this

secondary dissociation in many ways. One says that he is made up of two persons, one right and the other, wrong; one God and the other, the devil (the infantile motive and the ego-ideal). Another says that he is one person at night and another during the day. Still another states that he hears voices in his left ear or on his left side telling him to do this (bad) thing, while a voice on the right side tells him not to do it—again the infantile motive and the ego-ideal or conscience. The corrective or good influence is heard in the right ear in right-handed persons, the association of right and left, right and wrong. (Many schizophrenics were left-handed in infancy or remained so, a fact which must be noted.) This hallucination of hearing has a well-grounded meaning for all persons. We speak of the "voice of conscience" which even in normal persons may exert so strong a pressure that it can almost, or indeed actually seem to be heard. The returned infantile motive and the ego-ideal or conscience are the voices which the patient hears talking. The ego-ideal is associated with an image of personality and is stratified or introdetermined into the "they." So the "they" are calling him a spy (his method of gaining information as a child); "they" are going to punish him in some way, or accuse him or threaten him. (For full discussion the reader is referred to *Psychology of War and Schizophrenia* by the writer.¹)

With the removal of the environmental situation which caused the contraction of the field of consciousness through fear, the patient may return to the pseudo-adult level by repressing the memory of the whole phantasy experience. But this return is with a selective contraction of the field of consciousness, an amnesia. So long as this repression continues there can be no sublimation of the infantile urges, no progress toward an adult personality. But if adjusting to a pseudo-adult reality creates a third intolerable situation, he cannot recover in this manner. Those obstacles which he now faces are the factors which originally caused the

fear of self or of the environment such as returning to an intolerable marital situation where he is afraid of the wife or of his unjustifiable impulses toward her, where love for the wife has been lost or excites disgust or hatred; or where there is a great sense of conscious guilt for sensuous acts; a great sense of inferiority, shame, guilt or inadequacy; a great sense of social failure, fear of inability to dominate the environment and find an outlet for the will to power, inability to provide for himself and family, etc.

If the fear of environment is not removed and the fear of the reactivated infantile situation is sufficiently intense, *there is a complete dissociation. Regression also becomes complete and he identifies himself with the infantile image of himself as a child, an embryo, or even as dead.* He returns to the de-differentiation of the infantile stage, all excretory repressions are removed, clothing is destroyed, and he often wraps himself in a blanket, a symbol of the mother's body of his infantile birth fancies. (This is also doubly effective because the blanket acts to supercharge the air breathed with carbon-dioxide which reduces autonomic spasm. Carbon dioxide has been used in the treatment of the catatonic type.) During treatment it is common enough to see the patient retrace his steps toward adult life, saying that he feels first like a little child, then as he did at eight or ten years, then as a post-adolescent, etc.

When the man returns to his infantile emotional expression, the ego-conflict reactivates the feeling of inferiority and other conflicts which the ego cannot accept as belonging to it. The ego will not admit these motives as a part of it, and seeks an excuse for them. They are symbolized in some form, the stage of rationalization of inferiority. But even this symbolism connotes a certain degree of responsibility which is intolerable, and finally the symbols are projected upon the environment in the form of blame and are cast entirely out of the ego in the delusions. This is the stage

of projection of inferiority rationalization. One of the commonest forms of this projection is the delusion of grandeur, or other eccentric compensation, the stage of over-compensation for inferiority.

B. The Degrees of Regression

The tendency in regression is to return to the nursing period, to the time when the child identified himself with the man- or woman-images and depended upon them. The Oedipus complex is reactivated in both its phases in his phantasies. He may not reach this lowest level, returning only to the stage of auto-eroticism or homo-eroticism. These stages are often seen during the descent from or ascent to the adult level. These levels can be determined only by an analysis of the delusional systems which show the form in which energy is gratified expression.

C. The Endocrine of Regression

Corresponding with each of these changes of regression there are changes in the endocrines. In the early stages when fear is dominant there is over-activity with hyper-adrenalism, and high blood pressure. The thyroid may enter the picture with an opposing hyperthyroidism. If this stage continues there may be actual degenerative changes in the nervous system and brain. The influence of these endocrines may gradually destroy the glands which they oppose, especially the gonads. With the onset of the regression the hyperkinetic drive is no longer maintained or becomes exhausted so that the adrenal cortex, thyroid and posterior pituitary gain control. The dominant posterior pituitary supports the delusional system. There is usually disturbance of the gonads, the development of feminine sex characteristics, absence of beard, etc. When the onset is after the changes of adolescence, these physical changes are less marked. Degenerative changes appear after the regression has been apparent for some years.

D. Emotional Deterioration in Regression

The analysis of the psychological state from the standpoint of descriptive psychiatry is wholly inadequate. The facts of regression, not the undisturbed part of the field of consciousness are the important factor. Although the patient is oriented with a fairly clear state of consciousness and the memory but little disturbed, still the judgment may be impaired and the emotional state deteriorated. A close study of the field of the subconscious shows emotional deterioration, a delusional system, a regressed personality. One minute the patient may give his correct name and address, the next say that he is Columbus, that it is 1492 or that he is dead. To be oriented means to have a correct appreciation of time and space in reality. This the hebephrenic schizophrenic does not have.

In his subconscious field the schizophrenic has *a great disturbance or loss of the sense of space* which affects not only his appreciation of external reality, but also of his own body. It is this subconscious field which is important. He has a *great expansion of the sense of time*, so that the present includes all of the past. The present time is associated with fear, and hence he replaces it by the past. *The state of consciousness is also seriously disturbed, with the characteristic splitting both with relation to adult personality and in the subconscious personality.* Memory is seriously affected, there being no conscious memory in the restricted field. Judgment is necessarily impaired with such a great loss of conscious reality. In the restricted field, judgment is that of a child on account of the loss of adult memory. The old memory store (subconscious) is unaffected, but the power of adding new memories is progressively reduced through the loss of reality.

One of the fundamental characteristics of hebephrenic schizophrenia is the *emotional deterioration in the conscious field*. But when we analyze the delusional system we find that there is no

emotional loss. On the contrary, emotional activity is greatly increased, as we should expect to find from the law of psychophysical equilibrium. (Briefly, this is the constant struggle of the body-mind to establish and maintain a physico-mental equilibrium—a balancing of the physico-mental in time and space.) The patient gives his whole life over to the play of emotions. The delusional system is an expression of his increased emotional activity, which has been de-differentiated and comes to the surface of an infantile level, now anxious, now sad, now mirthful or progressively apathetic in appearance. The emotional loss is only in the conscious field.

Emotional regression is a very common mechanism. On a ward of 80 patients 30 were conscious of their feelings. The following abstracts were taken from their statements. All of them except the first were cases of schizophrenia. The first abstract, that of a manic-depressive manic type, is taken from the patient's voluntary description of his emotional life, and illustrates several points not found in the cases of schizophrenia:

Before coming to the hospital the patient wrote an article "How It Feels to Die" in which he described the influences which resulted in the development of his pseudo-adult personality; those which lead up to the traumatic moment and his emotions at the break. When he wrote the article he had returned more or less completely to the pseudo-adult stage with the insight of a manic. His description is, of course, a rationalization.

"As well as I know the sun, the air, and the earth, I have known death. From the day of my infancy I learned of the Bogie man. Fear dominated my character. The coward tendency became accentuated. Supersensitiveness and timidity. Fear of fistic combat and turning somersaults in the water. Abuse of a bully. Fear in football. Conflict over enlistment. Elation after weeks of inner war when I enlisted. When I

worked in the mines fear of caveins, foreigners, accidents, and of the boss, who was a gorilla. Fear of a girl. After six weeks of college left for home defeated. Fear of insanity."

"Sought out an old enemy and challenged him. Felt courage, Entered newspaper field. Girl deserted me. Fear returned. Felt the intuition of death. Landscapes-became distorted (disturbance of the sense of space). Sun was black. Felt like a murderer in death chamber awaiting death. Trembled visibly. Tornadoes of terror shook me. Bought a revolver. Loaded and cocked it, but did not have the courage to pull the trigger. Tried to drown myself. When I came out of the water the houses seemed to jump at me. Motor cars, sidewalks, poles and people swirled about me. The world collapsed. I felt myself sinking, sinking, somewhere, somewhere." (Confusion.)

"I felt no hunger, could taste nothing, forgot to eat, never slept. Day and night were the same to me! (Expansion of the sense of time.)

"I daresay I shall always be a cold-blooded individual; who wouldn't were he born at 21? The poor sensitive soul who occupied this my body in its youth is gone—forgotten and unmourned even by myself." (Dissolution) (The regression is sensed as having been complete. He was born (again) at 21.

About a year later he returned to college, entered another excited period and was returned to the hospital in a hypomanic condition. During this attack he again regressed to the infantile, cried like a baby, had loss of excretory inhibitions, tore off his clothes, and remained nude. He was muttering and incoherent. His pulse averaged 50, but was observed as low as 40. When returning to the pseudo-adult level he blamed one person after another for his failures (rationalization), said everyone about him appeared incompetent,

while to himself he was the acme of ability and perfection (overcompensation). He talked about being the Holy Ghost and stated that he was God and the Christ. (Projection, with spiritualization.)

He gradually emerged from the manic state and entered the depressed phase, with a feeling of unreality. His voice seemed far off (Loss of sense of space).

He had a feeling of life-long inferiority with shame and guilt, and of being a physical coward. He had a deep feeling of femininity. During the excited phase he thought he was a king; that a large number of persons were killed indirectly through him; that he was persecuted by the Masons. He acted like a spoiled child. He had fears of inferiority and of making a living. There was great limitation of his "will to power" and of his creative energy. The patient returned to his pseudo-adult level with some remaining depression and apathy.

The following short abstracts were made from the others on the ward. Only the salient features of the regression will be given:

Patient said that his body feels smaller, about 5 feet tall. He feels that his spirit changes into a girl. Then he feels smaller. His spirit goes out and the spirit of the girl comes in. The girl is 5 years old.

Another stated that he feels younger, has a smaller head; feels ten years younger. He cannot think like a grown up person. His head feels "all head." His head feels as large as an orange or the size of a small coconut.

Still another says that he is getting older, that a change came over him. He felt that he had died. Then he felt numb and finally felt as though he were 3 years old. He cannot "figure out" what killed him.

Another: Volunteered that until about a month ago he felt smaller, weighed about 20 pounds and was as tall as a table.

Another was doped on the Atlantic coming to this country. Feels that he is still paralyzed on both sides. Is getting ready to die. The cords from his lungs are decaying. He is shrunken so that he is very much smaller than he formerly was. The cords from his heart and lungs were burned in Henry Ford's hospital. The whole world has changed.

Another is very delusional, has \$2,000,000,000. Says he feels just like a child of 3 years old and wants to talk baby talk.

Patient is monosyllabic, hangs his head, laughs and talks in a silly manner. Several years ago he began to feel like a child again. Imagined he had returned completely to the nursing age. When he grew up again parts of his body remained shrunken, especially his chest. At times he imagines that he is a little baby.

Among the others, one felt as though the skin had been stripped from his body; another heard a ventriloquist throwing his voice about the ward at night. He felt 2 months old. Another re-enacts his childhood experiences like sitting on his grandmother's knee. His left side feels shrunken. Another says he has been dead for 15 years; another felt about 8 or 9 years old and about 4 feet tall. Another, 7 years old. Another died four or five times. Another "went back five devils," died four or five times. Another felt 4 feet tall; one 6 years old. Another felt he was growing upside down.

Many other variations were noted. One had had repeated regressions. He stated that there are two types of men—evolutionists and capitulationists. The first go forward, the others backward. He was an evolutionist. He was going forward, getting older. He explained that he had slipped back to the age of 10, then to 5 and then to 3 years. He felt paralyzed all over, very numb, like a baby; that he had lost every friend in the world, like the Craci in Rome; that he had lost all his

brothers and was alone like Robinson Crusoe; was less than half his present size; that he had no legs or feet left. He stated that he had been terror stricken in the hospital "because he was so small that he was afraid that if they put him in the bathtub he would go down through the waste pipe into the drain! Another felt six and a half inches tall. Many other examples could be given.

Fear, the great destructive emotion, is generated in two ways: (1) The emotions are ambivalent and repression of love results in the freeing of fear. (2) Sensations from the environment stimulate either the autonomic or the sympathetic or else the glands of internal secretion, resulting in visceral tensions and endocrine states with the production of fear, the scientific basis of which was given by Walter B. Cannon².

The effect of fear on consciousness is the opposite of love. Consciousness is greatly constricted and distorted, so that the sense of time is greatly expanded and the sense of space is disturbed, contracted, or lost. In involuntal melancholia, for instance, the patient experiences an almost overwhelming sense of the interminable minute. When a person falls from a high building there is a constriction of consciousness so that the memory of all of the events of his life may pass through the mind while falling. The acute psychosis called "stage fright" is another example of the effect of fear on the personality. Various drugs, such as alcohol, caffeine, morphine, hashish, cocaine, and general anaesthetics produce the same phenomena.

During day-dreaming there is a temporary regression. Consciousness is constricted so that the present is lost and replaced by an ecstasy of the future. The subconscious wish dominates the picture. In the expansive type of day-dream the limitations of space are overcome and the ideas approach an infinity of expansion so that the person may imagine that he is a millionaire or a god. In the opposite type the loss of the sense of space may reach

an infinity of annihilation—that is, death. We may sum this up in the statement that love expands the sense of space and contracts the sense of time; fear expands the sense of time and contracts the sense of space. If these contractions are continued there may be loss of a part of the field of consciousness and the development of a new personality. These were seen in the examples of regression just given.

The endocrine effects of fear with the production of hyperadrenalism, glycosuria, hyperthyroidism, and rejuvenation of the thymus and the actual degenerative changes in the nervous system have been described by Crile³ and Cushing⁴.

VI. The Cause of Schizophrenia

The cause of schizophrenia is not known. There are two diametrically opposite schools of thought: the psychogenetic and the somatogenetic. These widely divergent points of view develop from the lack of unity among psychiatrists in their basic philosophy.

The psychogenetic school believes that schizophrenia represents a definite type of personality disorganization which limits the patient's ability to adapt himself to reality. The basis of this personality are the early experiences and conflicts resulting in the repression of instinctive urges and cravings, with inevitable feelings of guilt and insecurity. The patient remains infantile in his methods of personal adaptation in dealing with his primitive instincts represented by the demand for nutrition, striving for perfection, the will to power, the pressure of his sexual craving, and so on.

As a subhead under the psychogenetic is the theory held by some psychiatrists that schizophrenia is a result of a conflict between the masculine and the feminine elements in a personality, especially expounded by Otto Rank.⁵ They think that the student of abnormal psychology should familiarize himself with the work

of Rank, his interpretation of the masculine-feminine myth being an invaluable aid in understanding the play activities of normal children, the family romance of neurotics and the symptoms of the psychoses. The great value of the myth, these psychiatrists think, lies in understanding through it the early experiences of the boy (masculine image of personality) to free himself from the influence of his femininity as symbolized and referred to as the dependence upon the mother. In the paranoid type the "They" who persecute the victim is the indetermined bad man or woman image, really his perverse masculinity or femininity.

In the same manner, the student should, they think, familiarize himself with the Freudian interpretation of the day-dream and the origin of the two sets of mechanisms which result from the conflict of the primary or masculine and feminine images of personality. The explanation of the Freudian mechanism will be found in this material.

A modification of the strict psychogenetic concept followed the work of Cannon which showed that the emotions of pain, hunger, fear and rage induce excitement through the endocrines. A great many observations have appeared to support this view.

The second school believes that schizophrenia has a somatogenetic origin such as a lack of vitality of the germ cells, organic changes in the brain, disturbance of the acid-base equilibrium, variants in physique, etc. To this school the symptoms in the mental sphere are the results of a physical cause of which there is a very great number.

VII. The Treatment of Schizophrenia

The treatment of every case of schizophrenia is an individual problem. A critical study of most of the methods ever advocated has shown that they all succeed in some patients when judiciously used, but fail with other patients when used indiscriminantly.

The first requisite is to remove the patient from the environment

which has caused him fear and pain. The patient himself has shown the need for this in his attempts to seclude himself and in his withdrawal from social contacts. This may not, however, be possible since the source of pain may be within himself, such for example, as a physical origin of a painful inferiority.

Before puberty relief from a painful environment may often be accomplished by sending him to a child guidance clinic, private physician or other social agency *competent to cope with major psychiatric problems*. Here he may be educated or instructed out of his fears. These measures will probably fail, however, unless the cooperation of the parents can be secured. Indeed, in many instances the problem is to change the family environment so that it will not produce fear, as of a brutal father. The parents must gain insight into the psychological problem. At this stage the treatment may be largely the treatment of the parents. The family situation must be corrected in addition to inculcating into the patient all of the highest concepts of human ethics, an instruction which must be based upon scientific facts and accomplished with sympathy but without reproach. The family situation is often a desperately difficult one. The social failure to face this problem is one of the major defects of our educational system.

After puberty, isolation in an institution may be necessary. Out-patient treatment is sometimes successful, but in the majority of cases is a waste of very valuable time.

The second requisite is, therefore, to reconstruct the emotional life of the patient by removing his fear reactions. This cannot be done by repressing of fear but by substituting normal emotions for destructive ones. The process is essentially one of education. If one understands the psychological aspects of regression these principles are easily grasped. Regression is the result of faulty association of fear, its dissociation or pathological integration. These fears must be eliminated. Ideas formerly associated with fear must be reassociated with pleasant emotion by re-education

and instruction. Fear must be eliminated. The writer has discussed this subject in his articles on the treatment of dementia praecox by lectures in mental re-education.⁶

During this isolation the patient must not be permitted to regress. Regression will not occur if the re-education of the patient is being successful. Every school of treatment has its methods to prevent it. Strict Freudian psychotherapy was discouraged by Freud himself but has been successful in a modified technique. Group psychotherapy is more likely to succeed than the individual method. Nursing and routine medical treatment must not be neglected. Occupational therapy is ordinarily very useful. Hydrotherapy to reduce physical tensions is the most successful in the excited types. The objective in these treatments is to interest the patients in contacts with reality which are painless to him until psychotherapy is successful. Among the pitiful failures in the treatment of schizophrenia is the mere elevation of the problem from the physical level to the symbolic level which leaves the patient more delusional and hallucinated than before. He may be more esthetic and more socially acceptable, but not fundamentally improved.

Of late years, the most successful forms of treatment have been essentially physical in nature. Dr. Manfred Sakel introduced his method of treatment by so called "shock doses" of insulin, at Pauling, New York. Even yet little is understood of the rationale of this treatment because emphasis was placed upon the metabolism of carbohydrate by insulin. The initial action of insulin is, however, a dehydration of the body protein. After the first two or three injections the effect is a gradual increase in the hydration of these particles. Glucose is used to counteract the effect of insulin because it produces dehydration of the hydrated particles.

With the mistaken idea that the so called shock is the cause of the improvement, metrazol (cardiazol in Europe) has been used extensively. Metrazol, however, causes a dispersion of the hy-

drated body colloids. The first action is one of hydration followed by dehydration.

The latest of the shock therapies is where an electrical current is used to produce the convulsive seizures. Whether or not it succeeds will probably depend upon whether or not the technique restores the negative electrical potential to the depleted (condensed) body colloids. For a more exhaustive discussion of the techniques themselves, reference is made to texts on the subject.

VIII. The Prognosis in Schizophrenia

A discussion of the prognosis in schizophrenia as an abstract subject is wholly worthless. The types vary widely in their probable outcome. Cases which have existed for over a year rarely recover entirely. Most cases are "improved" or in partial remission, so that one must define what is meant by "cure, improvement or remission." The acute cases are much more hopeful. Much depends on whether or not insight can be gained into the patient's sources of fear, his methods of reaction and of repressing that fear.

Despite this rather pessimistic statement, it is the writer's personal belief that a great many cases of acute schizophrenia recover spontaneously often without having been recognized as such; that the outlook for recovery or remission on a slightly lower level is good in those cases where treatment is undertaken early, that is within the first year, and where the fear which has caused the personality changes can be resolved. Nor is the outlook in the older cases absolutely hopeless; occasionally an old case suddenly recovers without treatment. This is less likely to occur in the paranoid types; but not necessarily so. One of the writer's exceedingly severe cases of the paranoid type recovered spontaneously within a month after the death of a mother who had dominated and dictated his every action since childhood.

In conclusion, the writer wishes to express the opinion that

every case of schizophrenia is accessible to the proper manner of approach; that together with the psychopath, criminal, neurotic, and psychotic, the schizophrenic has developed from the pressure of the reality principle, a burden which Society, itself, has placed upon them; that the desertion of these patients by placing them in custodial institutions without an effort to assist them to recovery, is an **INDICTMENT OF SOCIETY**, a public refusal to face the moral responsibility which Society owes to the individual, a responsibility which stands for progress and for that great expansion of human consciousness upon which the peace of nations depends and upon which the corner-stone of individual happiness is laid.

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Chapter XVII

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JOHN H. ADAMS, M.D.

Professor of Psychiatry, Harvard Medical School

and

Chief, Geriatric Department, Massachusetts General Hospital

Boston, Massachusetts

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I. Introduction

Senile and Involutional Psychoses. These are severe mental disorders which occur in older patients. In this chapter they are discussed as to etiology, pathology, symptomatology and treatment.

Advancing years do not preclude the development of mental disturbances which more commonly make their first appearance in earlier life and recurrent episodes of illnesses previously suffered may occur at any time. In addition there are conditions more particularly related to the climacteric and to later life. These appear in individuals whose development and earlier life experience has rendered them poorly equipped to withstand the particular stresses of this period of life. These disorders include the functional psychoses classified as the involutional psychoses and the mental states related to degenerative organic changes in the brain: senile psychosis and arteriosclerotic psychosis.

II. Involutional Psychoses

This group includes the depressions known as involutional melancholia and other psychotic conditions, notably paranoid states, which may develop in the same age group. These types differ not only in their clinical manifestations but also in their response to treatment and will be discussed separately.

A. Involutional Melancholia

This entity is one of the group known as affective disorders. Affect refers to the feeling associated with experience. Involutional melancholia and panic-depressive psychosis are therefore known as affective disorders because in these conditions the primary disturbance which is seen is one of emotion, mood, or affect as contrasted with psychoses of the schizophrenic type in which the fundamental disruption is seen as a disorder of thinking or cognition.

Kraepelin in first formulating his great classification of the mental disorders designated those depressions which occur at the involutional period, or climacteric, as melancholia. This was disputed by others who held that these cases belonged to the manic-depressive group and should not be separately identified. The greater number of observers came to accept the earlier view, namely that involutional melancholia is a distinct and fairly common disorder having characteristic features of its own.^{1 2 3} The basic studies in the development of this postulate were descriptive in character and dealt with observational data. Dynamic psychology has disclosed basic mechanisms operative in the development of depressions per se but as the observational and therapeutic characteristics remain, so does the practical value of the diagnostic category. In general patients who present this condition have not had previous mental illness of incapacitating degree and the diagnosis is reserved for those whose past history does not reveal previous pathological alterations of mood. In most instances these latter will be placed in the manic-depressive group.

1. Etiology and Psychopathology

The involutional period in both men and women is a time when important changes in bodily physiology take place. Most prominent are the endocrine alterations which accompany the meno-

pause. Efforts at understanding involutional melancholia led to the hypothesis that in these changes and cessations in the functions of some of the ductless glands were to be found the causal factors of this emotional illness. Investigations have not substantiated this view and such studies as those of Carlson⁴ reveal no discernable difference in the endocrine status of psychotic and non-psychotic persons at the time of the involution. Declining ovarian function and diminishing testicular production may contribute to the illness in a manner to be described below, but just as a specific role in etiology has not been demonstrated, so treatment regimes based on hormone replacement have proven disappointing.

Understanding of the disorder is to be found in the patient's psychological reactions on reaching that period in life where capacities diminish and opportunities fade. Before considering these reactions more closely it will be of value to consider what manner of person is prone to develop this condition and to note a few facts regarding age, race and sex distribution.

The involutional period cannot be precisely defined but it may be approximately designated as that from forty to fifty-five years in women and fifty to sixty-five years in men. A parallel age distribution pertains to involutional melancholia. The average age of men developing the illness slightly exceeds that of women while women develop the syndrome more frequently than do men in the ratio of about 3:2. One statistical study⁵ reports the average age at the time of admission to hospital as forty-nine years. A range of thirty years, from forty to seventy, is noted as that in which the disturbance emerges. In terms of physiological age and, presumably, endocrine status Wittson⁵ notes considerable variation. Forty-seven percent of the women in his statistical survey developed the psychosis during the actual period of the menopause. Thus in roughly half the cases the mental symptoms develop either before or after the organic event whose name they have been given. Melancholia developing ten years after the menopause is

seen with regularity in mental hospitals and the onset has followed the change of life by more than twenty years.

Observations from widely separated geographic districts reveal the unusual fact that the incidence of involutional melancholia is higher among rural than among urban population.^{1 5} The most prominent point observed regarding the ethnic distribution is that the incidence among Negroes is markedly lower than that among whites.

In describing the pre-morbid personalities of patients suffering from this disorder such adjectives as meticulous, over-sensitive and conscientious find common employment. These people are not usually introverted but they tend to have a narrow range of interests and activities. They are often rigid and unbending and are inclined to be intolerant of those whose views do not coincide with their own. Frequently they are overly scrupulous, a fact which heightens by contrast the personality change as seen in the course of the illness when self-abnegation, self-depreciation and self-accusations are prominent features.

These personality characteristics are not accidents. They are important to the individual for they are the more obvious facets of psychological defense mechanisms which serve to allay anxiety and act to hold back from consciousness hostile and libidinous impulses whose existence must be denied as they represent threats and dangers. The adjectives in the preceding paragraph connote exaggerated qualities and thus portray personality types which tend to require the exertion of continual exaggerated effort in order to maintain social adjustment. Davidoff⁶ has stated that in 70% of cases the history clearly reveals a poorly integrated pre-morbid personality. Where the prior adjustment appears to have been more satisfactory it can be said that this apparent success was based upon overdependence on some particular source of gratification which advancing years in actuality or in fantasy took away.

The studies of psychoanalytic psychology^{7 9 10} have shown the symptom of melancholia to be a response, exaggerated in degree, to the loss of a love object. This loss may be real or it may be imaginary just as the objects may be real or imaginary (fantasied). A person who reacts to this with such symptom formation is one whose childhood experiences have been such as to render him particularly incapable of enduring such a loss. His ego has required much in the way of reassurance. His doubts and his fears have needed constantly to be assuaged. His self-esteem depends on external supplies to a degree that Fenichel¹⁰ has called "addiction." When he perceives the loss of that object relied upon as a love-source of prime importance, he experiences a feeling of emptiness and of being forsaken. His self-esteem is threatened to a dangerous degree. An ego thus deprived suffers a great reduction in its powers of adaptation. Effective reorganization of emotional forces with the formation of new object attachments is necessary for the maintenance of a workable emotional balance. Illness results when the loss so overwhelms the ego as to render it incapable of carrying out this reorganization.

Those so deprived feel that life is no longer worth living. In addition they behave as though they were personally responsible for incurring the loss, therefore guilty and not worthy to live. This aspect of culpability and guilt stems from unconscious feelings of a hostile nature which lie concealed beneath the love. This duality or bipolarity of emotion is known as ambivalence.

The hostility or resentment has a number of sources. In such a person the need for love is a passive one. He needs to be loved. The adequate continuing gratification of this need is essential for preserving the integration of his personality. This pronounced dependence on the love-object places this person in a difficult and vulnerable situation, sensitive to every slight and affront yet unable, because of his needs, to react to these with appropriate aggressivity. Hostility and resentment must result from being so

subjugated and so at the mercy of another. It is a quality of immaturity to react violently to frustration. It is a quality of dependence to be submissive. Here then is a conflict in the personality structure of those susceptible to depressive reactions. Another quality found to exist in those who have been unable, because of the circumstances of their development, to achieve greater emotional maturity is their inability to obtain true satisfaction. Outwardly the submissive facade may permit only such evidence of dissatisfaction as irritability, hypercriticalness or jealousy to appear but the needs of these people are not satisfied by usual amounts of love and support. An addiction requires an ever-increasing intake. Similarly these demands are well nigh insatiable and so are certain to suffer frustration whether the source looked to for gratification is truly generous or not. The necessary concomitant is resentment and hostility.

Such resentment cannot be faced and must be denied for it is a dire threat to the person's state of well being. Hate produces hate in return. Hate would lead to rejection by the very object on whom so much reliance is placed. No matter how these feelings are denied conscious recognition they persist in the unconscious where their presence results in strong feelings of guilt. When the loss actually happens it is felt as a desertion. The long feared rejection has come to pass and the underlying resentment is now intensified by the reaction to this desertion.

A quantity of emotional energy is bound in every attachment. When the attachment is broken this energy becomes freed. In striving to recapture the gratification and security of love, and so the preservation of self-esteem, the effort is made to establish a new attachment. Successful attachment to a new external object is able to preserve the adjustment but in the pathological instance under consideration this does not happen. The personality type that has been described is an egocentric one wherein feelings of love are felt in terms of self. Self-love or narcissism is normal in

the infant and is the antithesis of emotional maturity. Few people achieve such mature equanimity as to be subjectively undisturbed by a profound threat to their fundamental self-evaluation. The inner awareness of changes in one's self, of loss of virility, vitality and capacity constitutes a severe narcissistic wound. The excessive narcissism as seen in this type of patient influences the reaction to a loss. He feels gravely threatened and must grasp unto himself every available support. The emotional energy mentioned above is not redirected outward but becomes turned upon the patient himself.

The normal personality in adjusting itself to a disappointing loss makes use of the mechanism of identification and so preserves a bit of departed person. Identification is an unconscious process by which one person (ego) transfers to itself properties belonging to another person (ego). The depressive patient carries this on to an enormously exaggerated degree. The description of this person has been one of a person who tends to "take in," and now to recapture his loss he carries identification to the point of incorporation and literally takes into himself all the feelings and attitudes which are for him the representation of the lost object. This attempt to deny the loss and to preserve the love-object is known as introjection.

The depressed patient says that he is lost or that he is unworthy. This reflects the patient's equating of himself and the object, for in actuality he has lost an object whom he has often viewed as unworthy. This process is fundamental in the development of the depression for with the introjection the hostile elements too become internalized and the anger originally felt toward the object is now, in effect, turned upon the patient himself. The aggressive impulses thus internalized act to reinforce the forces of guilt already present. This is the explanation of the patient's apparent attack upon himself. Thus the depressed state with its bitter self-depreciation which seems so out of keeping with external reality

is seen to be wholly appropriate to the underlying ideational content. The recriminations are not really meant to refer to the patient but represent the accusations originally directed toward the object.

To complete this brief survey of the formulations developed through the investigations of psychoanalytic psychology, and applicable to psychotic depressions in general, consideration must be given to the role of the super-ego. It is not the function of this chapter to discuss super-ego development or to elaborate on the definitive nature of this component of the psychic apparatus but a descriptive consideration of the depressed patient reveals him to be one in whom the conscience has come to represent practically the whole of the personality. The incorporated forces described in the preceeding paragraphs join with the super-ego and reinforce the already powerful conscience. The shrunken and depleted ego falls totally under the tyrannical sway of this power. It is the super-ego which now treats the ego as the patient's repressed unconscious hatred would have treated the lost object.

With an outline of the psychic mechanisms in mind the rather prominent tendency for depressions to occur at the involutional period becomes more understandable. These mechanisms are unconscious. Their powerful forces lie unseen and unrecognized by the individual. There are clues and personality traits which suggest their existence to the trained observer but only through the use of highly specialized psychological techniques can the actual thoughts properly associated with the feelings be brought to conscious recognition.

In every person repressed ideas are kept from consciousness. The healthy as well as the ailing personality utilizes psychological defense mechanisms. The efficacy of the mechanisms depends upon their ability to permit the individual adequate gratification of his needs and maintenance of his self-esteem while at the same time maintaining adequate social integration. Illness supervenes when the defenses can no longer accommodate to the stresses of a situa-

tion. A retreat is made to more primitive defenses. This is known as regression. Regression implies the use of mechanism of a lower order and therefore less effective in terms of social integration. This shift in defenses involves what we recognize as symptom formation. As a result the person is now less adaptive, less free in directing his actions and, therefore, less well integrated. A reduction of the stress which caused this regression should then result in a change toward the original more adequate level of function. This has been found to be true.⁸ An equilibrium exists in the psychic apparatus and the actions are reversible though for practical purposes this cannot always be achieved in the practice of psychological medicine.

The involutional period presents its special features which tend to disrupt this equilibrium. The person now reaches a point in life when recognition of failures and frustrations can only with difficulty be offset by dreams and plans of achievements to come. His actual powers have begun to wane. Certain activities must of necessity be curtailed and if among these are factors on which the person has placed great reliance for the maintenance of his well being the loss will be keenly felt. The ageing person, settled in the habits and manners of several decades, knows himself to be less flexible in adjusting to changing situations than he was in his youth, and this at a time when much about him is changing. His productivity is declining. His children have moved away, their interests now centered in activities of their own, and other loved ones have been taken by death. The spinster can no longer live in hopeful expectation and the bankrupt has scarcely a chance of recouping a lost fortune. It is of course true, as has been pointed out by Karl A. Menninger,⁹ that an opposite reaction may occur. A person may react to the challenge in the above situation with vigorous positive action and so effect an excellent compromise. Beyond the influence of the generally presumed, but undemonstrable, con-

stitutional factors the direction of the response is determined by the status of the psyche.

2. Symptomatology

Some mild degree of personality alteration is commonly seen at the involutional period. Irritability, petulance and a pessimistic outlook are apt to appear and frequently there is insomnia. These more minor symptoms may remain more or less fixed, may abate, or may merge with what prove to be the prodromal manifestations of an involutional psychosis. With the latter progression the emotional tone becomes more melancholy, crying spells occur at times, and there is increasing loss of interest in the environment coupled with a disinclination to activity.

In the typical established case of melancholia the most prominent features are marked depression, anxiety and agitation, hypochondriacal trends, ideas of sinfulness and unworthiness, and somatic delusions, commonly of a nihilistic character. Numerous authors have devised classifications in an effort to divide variations in the symptom picture into three or four sub-types. This is of doubtful value since here as in all mental disorders variations are the rule and no two cases are ever exactly alike.

Outlined as to categories the common symptoms which may appear are as follows:

Attitude and General Appearance:

The patient appears miserable and woebegone. He is thin and sallow. Though often unresponsive he is capable of answering general questions in an appropriate manner. His voice is low, sometimes harsh, and monotonous. He has little real interest in his environment but is anxious and may show all gradations of restlessness and agitation. He is lost and helpless, and is likely to plague the hospital staff with repetitious complaints and requests for reassurance though these latter seem only to increase his doubts and his misery.

Perception:

His alertness is diminished but consciousness remains clear and he is correctly oriented for time, place and person although indifference to external matters because of the subjective focus of his attention may render him oblivious to the passage of time and otherwise result in apparent confusion. Bodily sensations are often misinterpreted lending force to hypochondriacal trends. There is a physiological slowing down attendant on depressive states. This affects particularly the gastro-intestinal tract, alters the usual "feeling" of the patient, and may contribute to feelings of unreality.

Intellection:

Poverty of thought is usual. There is a limitation in the scope of ideation and emphasis on ideas of a self-depreciatory and self-condemnatory nature. There tends to be wearisome repetition of the particular ideas with which the patient is obsessed. He combs his memories for possible indiscretions which then are submitted as fresh evidence of his unworthiness. Various delusions may be formed. There are those of the self-accusatory variety which have to do with the patient's guilt for misfortunes which have befallen others. Often he has committed an "unpardonable sin." Hypochondriacal delusions are seen. He may be certain he has cancer, or some other dread disease. There are the nihilistic delusions in which he may avow weakness because there is no blood in his veins or may refuse food because there are no longer any stomach or intestines in his abdomen. Intelligence is not affected although judgment is impaired. Real insight is lacking but he usually recognizes that something is wrong and to some extent appreciates that he is ill. He entertains no doubts, however, about any of his delusional ideas.

Emotion:

Depression is basic and can reach the most profound degree. With this there is associated anxiety and the affect of appre-

hension. There are minimal affective responses to environmental stimuli. The depressed mood is in harmony with the patient's thought content although it may appear inappropriate to the external situation. In mild or early cases there may be an effort to conceal or minimize the depression consciously but in the established case there is no such dissimulation. Irritability, plaintiveness and other traits may be woven into the clinical picture.

Action:

The variations extend from states of apathy, which when extreme may appear catatonic-like, to marked over-activity. There may be little overt activity but evident tension and restlessness and there may be gross agitation with the patient pacing the floor, weeping, picking at his clothes or body, beating himself or striking the wall. He is not easily influenced and is often stubbornly uncooperative or even negativistic. Attempts at self-mutilation are not infrequent and the risk of suicide is very great. The appetite is poor which, coupled with the restlessness, leads to considerable weight loss. There is commonly constipation and a scanty output of urine. Insomnia is often very stubborn.

The following case summary illustrates many of the common features found in this disorder:

L. G., male, age 56, married, no children, was hospitalized on medical advice. He was the fifth of seven children raised in average circumstances. The parents had been generous: the father kindly; the mother rather strict. The patient had been socially inclined with a tendency to "show off." He preferred "individual" sports such as tennis or golf. He made a successful career as a salesman and at 30 married a woman of cultural and artistic accomplishment. He professed great devotion to her but continued his previous social patterns with very little change and stubbornly opposed her wish for children.

About two months prior to admission he began to show diminishing zeal for his work and to become careless in his erstwhile impeccable dress. Without offering any explanation he ceased visiting his golf club. He became moody and irascible. His wife's inquiries regarding his welfare were sometimes ignored, sometimes countered with angry responses. Two weeks before admission he stopped work altogether. Evident melancholy supplanted his former moodiness. When his wife remarked that he was bemoaning trivial affairs long since past he became angry and accused her of being callous to his suffering. On admission there was evident recent weight loss. He appeared tired and worn. His breath had a fetid odor. Although severely depressed he was able to give relevant historical data but was too preoccupied to know the date. During examinational procedures he could maintain a cooperative attitude for only brief periods between which he would lapse into subjective preoccupation, appear anguished, and make such statements as: "I don't deserve to be in a hospital. This is too good for me. I should be in jail." He spent most of the time sitting on his bed. Restless movements of his hands were nearly constant. He was severely constipated, had a poor appetite and slept poorly. He stated that his wife should divorce him because he was a hopeless failure. He soon began to approach the physician of his own volition and in a clinging manner to repeat his self-recriminatory theme accusing himself of having been a fraud all his life. He claimed that he had betrayed his employers and disgraced his family. He was the picture of abject misery. Electro-shock therapy was instituted. After three treatments his sensorium was clouded and orientation was impaired. After the seventh treatment his mood began to brighten and after the ninth the self-accusations were largely gone. The depression lifted and after the twelfth and last treatment a mild euphoria was present for three or four days. Clarity of consciousness

had been fully regained ten days after the last treatment and after the a further two weeks convalescence, during which time he had daily therapeutic interviews with his physician and a psychiatric social worker talked at length with his family, helping them to an understanding of the illness and helping them to plan for his return home, he was discharged from the hospital.

3. Course and Treatment

Much knowledge and understanding of the personality has been achieved but there remains limitations to the direct utilization of this understanding in the treatment of patients. The patient who is severely agitated and deeply depressed is well nigh unapproachable, initially, by psychological techniques. The psychic structure of patients who succumb to this type of disturbance has been described as rigid. Their personalities are brittle and resistant to change. In the case of an involutional disorder the age further mitigates against the possibility of meaningful alteration of character by psychological methods. This is occasionally possible but for general application is not practical. Furthermore these patients are suffering horribly from a condition with which certain real threats to life are associated. Such a situation calls for the prompt application of such methods, physical and psychological, as are of value in quieting the emotional storm.

The older treatment regimes relied primarily on watchful custody, sedation, and such adjuncts as occupational therapy. Sedation was sometimes used intensively with the patient being kept in a somnolent state for twenty to twenty-two hours out of twenty-four. Endocrine preparations had been tried with little result for some years so when estrogens of high potency became available in 1930 they were received with enthusiasm. One of the early reports on the use of these substances gave two social recoveries out of seven cases treated.¹² Later Werner¹³ made

sweeping claims for the specificity of theelin and claimed recovery rates as high as 92% with its use. The experience of other workers did not confirm these claims and the opinion spread that the specific usefulness of hormone preparations was in treating the menopausal symptoms just as in the non-depressed patient.

Electro-shock therapy, announced by Cerletti and Bini in 1938 (Rome) represented a technical advance over the earlier pharmacologic convulsive methods. The convulsive treatment was devised for the treatment of schizophrenia. Some years elapsed before its particular usefulness in the affective disorders was recognized. Now it is with these conditions that electro-shock treatments have their most valid application. Melancholics generally respond favorably whether they be retarded and apathetic or agitated.

In the case cited above there was a prompt favorable response to electro-shock therapy. When the melancholic patient cannot initially be approached by psychotherapeutic methods electro-shock therapy is indicated. This procedure should be combined with a planned hospital program providing as considerably as possible the watchful care the patient requires together with facilities for constructive, diverting and encouraging activity throughout the day. In the total treatment program consideration must be given to all aspects of the patient's milieu.

It is not within the scope of this chapter to consider the particulars of the methods and application of psychotherapy. A word must suffice to indicate that in a daily treatment program based on every possible psychological consideration the psychotherapeutic session is a focus of vital importance. Formal psychotherapy, as has been indicated, may have to be modified and deferred with the melancholic patient, but every professional contact with the patient permits the employment of psychological understanding of the patient, his problem and his needs and at the earliest possible moment more structured supportive and educative psychotherapeutic measures are indicated.

Just as there may be spontaneous remissions from this as from so many other disorders there may be remissions with the application of electro-shock treatments alone but it is when the physical methods are used as skillfully correlated adjuncts to psychologically planned management that the highest percentage of cases achieve satisfactory remissions and the relapse rate is reduced to a minimum. Statistical surveys now indicate remission rates of over 80% and some approach more closely to 100% of selected cases.¹¹ Prior to the development of therapy as described involutional melancholia ran a protracted course. Twenty-five to 30% of cases became chronic while an additional 20% succumbed to suicide or to some intercurrent disease before remission had been achieved. Many of those who did regain their emotional health to a degree permitting adjustment outside a hospital required one to four years to do so.

In an effort toward supporting the patient in his movement toward improvement particular emphasis should be given to the preparation for his return home. The services of a psychiatric social worker are of enormous value in conducting this portion of the therapy. The patient's family have had their own reaction to the illness. They may themselves be burdened by guilt. They need help in developing understanding of the problem and of how to handle it. The home environment needs to be studied to see what recommendations might be possible to make that situation more satisfactory for the convalescing patient and his family.

In those cases where the above treatment methods fail consideration may be given to pre-frontal lobotomy. Freeman and Watts have reported favorably on the application of this surgical procedure to involutional psychoses. They have used it as a primary treatment measure but because of the high remission rate obtained with psychological and convulsive treatment the general view favors reserving surgery for those patients who are not helped by the less radical techniques.

The growth of knowledge regarding personality structure and the understanding of the importance of developmental experience in its formation indicates that the real treatment of this and all other emotional disturbances is properly placed in the earliest periods of life. Prevention, that ultimate goal of medicine, is to be accomplished through the application of psychological knowledge. Much can be done to insure against processes of decline in later years by the proper emotional care of the child and his conflicts during his formative years.

B. Paranoid States

In addition to the predominantly depressive reaction of involutional melancholia the involutional psychosis may take a paranoid form. Here again the patient has not previously been considered psychotic but the pre-morbid personality generally reflects distinct evidence of imperfect emotional maturation. It is common for this person to have been critical, quick to take affront, obstinate, jealous and inclined toward suspiciousness. He has often shown great concern with details and a tendency to be fussy and often irritating in his punctiliousness. He may have demonstrated considerable drive and achievement.

Reference should be made to the chapter on paranoid psychosis for a delineation of those features which are defined as paranoid and for their particular meanings and significance. Briefly, the paranoid blames others for his misfortunes and imputes to the actions of others meanings having special reference to himself. His interpretations of reality can become grotesquely distorted and as the illness progresses there is a tendency similarly to distort and falsify the events which occurred in previous years. In the formation of melancholia the fundamental psychological mechanism was seen to be introjection. In paranoid development it is projection. Projection is the externalizing of conflictual material and forbidden impulses. The defensive value comes from

ascribing these things to others. The patient is able to proclaim his own virtue by playing the role of the outraged victim and the accuser. Thus other people are alleged to be talking about him and calling him names, people are looking at him or are forming conspiracies against him and so on.

In adolescence there is an upsurge of instinctual forces. Physical maturation adds new power to feelings and impulses. A desire or an idea which before puberty would have produced a rather small response in the realm of feeling now has a surcharge of affect. A workable adaptation to life requires the establishment of effective control over these new forces with their blending into a reasonably harmonious pattern. At the climacteric there is once again a resurgence of these forces. The harmony of earlier adult life may be strained by this disturbance of the libido. It may be a sort of over-compensation, a fight against the inevitable in which all of the instinctual forces are mobilized. Old ideas, old fantasies which for years have been more or less effectively subdued may now be so strengthened as to materially alter the emotional equilibrium. Urges toward perverse activity, for example, which may have been present in adolescence and repressed deeply in adulthood can now reappear and with this threat of forbidden impulses there is a mounting reaction of guilt. Ambivalent emotional attachments are areas of weakness at such a time for the awareness of the negative side, the hostility, can be very threatening. Thus a parent's resentment toward an ambivalently loved child can force its way toward consciousness. The maintenance of self-esteem, as previously discussed, requires that this must be denied and by projection the impulse can be attributed to the other person or displaced to still other people. The person who because of resentment first feels "I have not done enough for my children," meaning "have not sufficiently denied my hostility," may now reach a point where this device is not enough and by projection the resentment becomes "nobody loves me" or "they want to kill me."

As it does with the melancholic patient the period of life is seen to add stresses which in large measure account for the emergence of the defensive symptoms at this particular time. Not only is there the instinctual surge already mentioned but the realities of the situation do make it improbable that a person can rectify the injuries his selfishness and egocentricity have inflicted on others. The same ultimate frustrations indicated for the melancholic sufferers also apply here.

In the paranoid state the patient tends to be somewhat gloomy but the chief disturbance of affect, and it may be considerable, is seen in the feelings associated with his particular ideation. Although preoccupied with his particular focus of thought his suspiciousness tends to keep him exceedingly alert. As the process continues signs of intellectual deterioration may supervene. It is common, however, for involutional paranoid development to be more or less blended with a depressive picture so that a wide variety of clinical pictures may result.

The following case summary indicates some features seen in the paranoid type of involutional psychosis:

F. G., female, age 57, was hospitalized on the advice of her physician. She was the only child of middle-aged parents. In her school days she did not relate well to her classmates but was haughty and scornful and associated only with an exclusive clique. She married an energetic businessman. Her ambitions for him and her talents as a hostess made her appear to be a valuable wife. At 54, before the menopause had appeared, she became manifestly tense, somewhat agitated, and for several months did not display her usual interests. An abrupt exacerbation of symptoms immediately preceded her hospitalization.

At the time of admission she was moderately depressed and agitated. There was some confusion and impaired orientation. She said her husband was a "terrible man," that he was driving

her insane and was alienating her children from her. A course of electric shock treatments was administered and was followed by clearing of her confusion and lifting of her depression. She returned home but was unable to regain her former level of adjustment. She became more sloven in manner. Her manner became more and more one of irritability and aggressivity and though her wit and conversational ability could still be called into play when, for example, guests were present in the home, she spent increasing periods of time engaged in no purposeful activity and preoccupied with thoughts of the order noted at the onset of her illness.

The menopause began at 55 and was accompanied by mild menopausal symptoms such as hot flushes for which she was given endocrine preparations by her physician. She had no other organic disability. Her projective thinking became more marked and more affectively colored so that at home she frequently would rage at her husband and children. At other times she would appear quite apathetic. Upon rehospitalization (age 57) she appeared agitated and begged for "protection" from her husband and "help in getting my children back." She accused her husband of being a pervert and of making her sick because of this. On other occasions she would indignantly deny that anything was the matter with her and would insist that it was her husband who was ill and who should be in the hospital. Her condition failed to respond to treatment and continued to deteriorate so that custodial supervision became necessary about three years after the onset of the illness.

The recognition of prominent paranoid and manifestations in a given case has some significance in regard to prognosis. The outlook here is less hopeful than with the more purely melancholic condition. Most statistics indicate a remission rate of only slightly over 40% for these patients when treated with electro-shock and in addition those who do improve with this method require more

treatments than is usual with melancholia, a series of twenty being the number usually prescribed. On the other hand it must be borne in mind that statistics, gleaned as they are from many sources and summarizing treatment efforts which have varied considerably in their intensity, are often misleading when the treatment of one particular individual is being considered. A great many patients even though they may be utterly unmanageable at home are able to achieve a satisfactory social recovery through a period of hospitalization with the provision of an active program calculated to provide suitable permissible outlets for the patients aggressive impulses and to encourage the reconstitution of previously effective psychological defense mechanisms. Suitable psychotherapy is of course a requisite in any such program. Even the act of hospitalization is clearly helpful to some patients, freeing them as it does from environmental stresses and emotionally disturbing contacts while at the same time the seriousness of the total situation is emphasized and thus there is an appeal to the patient's capacities for restoration. The management of mild cases on an out-patient basis is a problem in psychotherapy and as such will not be discussed here.

It should be mentioned that lobotomy more often becomes indicated with these cases than with the melancholic. The chronic patient who shows strong emotional concomitants to his paranoid ideation may for years make life miserable for himself and for his environment. Lobotomy while entailing certain risks can be effective in divorcing the untoward affect from the ideation thus making the patient more comfortable and, after a necessary period of convalescence and reeducation, more tractable.

C. The Disorders of Senility

1. Senile Psychosis

Senescence, the process of ageing, through associated degenerative changes in such vital structures as the brain not infrequently

leads to specific emotional and intellectual impairments. A person far advanced in years may retain his faculties to a surprising degree but after about the 65th year it is not uncommon for early evidences of senility to appear. These include forgetfulness, obstinacy and diminishing interest in the environment. When the impairment does not progress beyond this level the condition is ordinarily considered to be within normal limits but there is a gradation, without any arbitrary lines of demarcation, down through simple deterioration to the state of simple dementia succinctly described by Shakespeare:

"Last scene of all,
That ends this strange eventful history,
Is second childishness and mere oblivion,
Sans teeth, sans eyes, sans taste, sans everything."

2. Etiology and Pathology

The most apparent factors to which the mental symptoms can be related are the structural changes which coexist. Heredity and constitution are believed to influence the degenerative processes and some authors have found a familial tendency toward these changes. In the presence of mental deficiency, and with certain abuses such as alcoholism or prolonged physical or psychical strain, senile development tends to occur relatively early. Psychological factors too play a role. Persons having comparable brain damage whatever the cause are each handicapped and yet each may differ markedly in his management of the handicap. The stronger ego is better able to adapt to any change and thus more effectively to resist the onslaught of disabling symptoms.

A number of pathological alterations in structure develop. The entire brain shrinks in size. With this atrophy the convolutions on the surface of the brain become somewhat flattened. As a result of this the sulci, or crevasses which separate the convolutions, become widened. The meninges, the membranes which surround and cover the brain, become thickened. Microscopic examination of the

brain tissue shows that many nerve cells have disintegrated and disappeared. Formations known as senile plaques are found in many parts of the brain. These plaques consist of jumbled masses of tissue composed in part of neural elements and in part of connective tissue, or glial, elements. The reader who wishes a complete technical description of these pathological changes should consult a standard textbook of neurology or pathology.

3. Symptomatology

Failure of memory is an early and prominent feature. This failure at first affects memory for recent events while recollections of the past continue to be accurately maintained. As the condition advances the memory defect expands, extending farther and farther back through the years, and may come to include the patient's entire life span. With this pervasive forgetfulness the patient becomes utterly incapable of keeping track of things. He does not know where he has left his clothes, his glasses or his pipe. Since insight is characteristically lacking he is inclined to get suspicious, he often accuses other people of tampering with his property and pronounced paranoid trends become common. Diminishing attention to and interest in the environment accompany the impairment of memory. The gaps in his awareness are filled in by confabulations. He has an answer to a question but it may be quite irrelevant. Misidentifications are common. To persons in the current environment are attributed the names and qualities of others long since moved away or deceased. Orientation becomes progressively poorer. Time and place are first to become confused. In advanced states identity of person is also lost. There is a diffuse impairment of the ability to attend which, coupled with the frequent occurrence of restlessness, results in the patient's having a tendency to wander and to get lost.

There are both qualitative and quantitative emotional changes. The patient becomes more apathetic in his overall status but with

the diminishing interest in environment there comes irritability and petulance because his immediate personal needs become his chief concern. He wishes them gratified immediately and is intolerant of frustrations. Stubbornness may be marked. Certain routines often become so unvarying as to be ritualistic and he brooks no interference or change in them. Depressions of a mild degree are not uncommon.

A troublesome symptom when it occurs is a tendency toward sexual perversion. The elderly male may expose himself, attempt sodomy or other acts, and commonly this behavior is carried out with children.

The above manifestations of diffuse diminution in intellectual and emotional capacities with failing memory, judgment, and concentration describe the condition, with varying degrees, of some 50% of the senile psychotics. The remainder show certain variations and additions to the above of which delirious states and paranoid states are the most common. The delirious states develop abruptly and usually appear as complications of an illness, an accident or a surgical operation. The patient is extremely restless. His status approaches acute mania and the danger from exhaustion is very great. The paranoid states, and those complicated by marked depression, present these additional features superimposed on the basic deterioration. The paranoid senile patient handicapped as he is by his lack of judgment and discrimination is likely to commit impulsive acts of violence and should always be regarded as dangerous. A presbyophrenic type is described where despite severe loss of memory and disorientation mental alertness is preserved. These patients are fully aware of the events and people about them. Because of their poor retentive capacity they resort to an extreme degree of confabulation.

4. Management

The care of the senile patient is entirely symptomatic with the

addition of such safeguards as may be necessary. Early indications of deterioration are of importance in that they indicate the possibility of failing judgment and moral restraint. The patient's relatives should be made aware of this and steps should be taken to guard against the senile patient's being victimized by unscrupulous persons. Supervision is necessary and must be particularly close in the case of those showing paranoid trends. Such patients are best managed by hospitalization whereas the case of simple deterioration may be cared for at home for a long period of time. Diet and the functions of elimination need to be watched. Insomnia affects the majority of senile patients. The usual sedatives must be used with caution since their elimination from the body is dangerously slowed down by impairment in liver and kidney function. Whiskey is often the sedative of choice.

D. Arteriosclerotic Psychosis

Arteriosclerosis is a well nigh universal concomitant of aging. This process involves structural changes in the blood vessels of the body, thickening and other alteration of certain layers within their walls, which results in an impaired blood supply to the area whose nourishment depends on the affected vessels. Individuals vary widely not only in the degree to which they develop arteriosclerotic changes but also in regard to the particular blood vessels which are most affected. For example involvement of the vessels of the brain may occur along with widespread sclerotic changes throughout the body of one person while in another the vessels of the brain may be the only ones to be significantly altered and in yet another some portions of the body may show considerable evidence of the change while the vessels of the brain are spared.

Arteriosclerotic brain disease generally makes its appearance after the age of fifty but often earlier than the usual onset of senile dementia. It is often difficult to differentiate the two condi-

tions and by the age of sixty-five or seventy arteriosclerosis not infrequently complicates the senile psychosis.

1. Etiology and Pathology

The entity of arteriosclerotic psychosis results from damage done to the brain secondary to sclerotic changes in its blood vessels. The nutrition of the brain is impaired by the disease of the blood vessels. This leads to the death of numbers of the nerve cells, a certain amount of replacement of these elements by glia, the connective tissue of the central nervous system, and some overall atrophy. Hemorrhages may result from degenerative weakening of the walls of the afflicted vessels. Apoplexy is the result of a severe hemorrhage although arteriosclerosis is only one of the conditions which may predispose a person to this. Lesser hemorrhages lead to the destruction of focal areas of the brain. Cysts may be formed in the nervous tissue and there may be areas of softening of the brain. The particular symptoms seen in a patient depend more or less upon the parts of the brain which have been most involved.

Admission rates to state hospitals indicate that the incidence of this disorder is rising. This increase parallels a general increase in diseases of the cardiovascular system, but is in contrast to the status of senile dementia where the incidence has shown little change in statistics from 1910 on.

It has been known for a long time that autopsies sometimes reveal the presence of arteriosclerotic changes, even the rigid, calcified, "pipe-stem" arteries, in the brain of a person who showed no sign or symptom of cerebral involvement during life. This suggests that there is variation between personalities in their capacity to accommodate to the insult of brain damage just as did the comparable situation described in the discussion of the degenerative changes of senility.

2. Symptomatology

Dizziness, headache, ringing in the ears and vague unpleasant subjective sensations, particularly in the head, are early symptoms of diffuse cerebral arteriosclerosis. Concentration not only becomes impaired but also fatiguing to the patient. At this stage, and the manifestations may never progress farther, the symptoms are not really specific and the error of ascribing to the symptoms a neurotic basis may be made. Such additional signs as hypertension, nephritis and, especially, arteriosclerotic changes in the vessels of the retina point to the true nature of the disease. Irritability and sudden, even extreme, mood swings are common. Such a development often represents an abrupt alteration in the patient's personality and will lead his family to make such statements as: "He seemed to be all right until about a year ago. Since then he has been disagreeable. He argues all the time and nothing ever satisfies him."

Certain behavioral changes may also develop. There is a tendency for the finer sensitivities to be lost, for ethical concepts and moral judgment to decay. A distressing lapse in the powers of inhibition may even be present as an early symptom. Sexual aggressivity or amoral sexual advances toward children may result.

From the general fatiguability and loss of initiative which may be prominent among the first complaints presented to the doctor the condition runs a progressive course with increasingly poorer adaptive ability. The speed of the progression varies greatly. The invariably fatal termination commonly comes with an apoplectic stroke or as a result of arteriosclerotic disease elsewhere in the body.

There is a final group of symptoms related more specifically to damage to a particular part of the brain. The varying paralyses which result from a stroke are examples of these. Paresis can follow destruction due to hemorrhage or that secondary to the

sclerotic occlusion of a vessel. In another area such damage can lead to aphasia. Aphasia is the loss of an acquired ability so that the victim, though his vocal cords retain their function, cannot use words or, though his sight remains, cannot read. Again it may be the ability to understand words that is lost. Sometimes these various types of losses are partial with the ability to utilize certain words or phrases remaining. The picture of Parkinson's syndrome or paralysis agitans with its increase in muscular rigidity, "pill rolling" tremor of the hands, lack of facial mobility and other signs is one whose milder manifestations, on an arteriosclerotic basis, is fairly commonly seen. Certain periodic manifestations can occur. Episodes of excitement and episodes of confusion may fall into this category as do convulsive disturbances. These latter range from focal twitching of a single member to more general epileptiform seizures.

Unlike the senile patient, the arteriosclerotic, until deterioration has progressed too far, recognizes the presence of illness and knows that his mental activity has become impaired. As the impairment progresses memory fails, that for recent events being first affected, orientation is lost and ultimately all powers of recognition and cognition are destroyed and a vegetative end state, total dementia, is reached.

3. Management

As in the case of the senile psychoses the management is symptomatic. There is no treatment for the underlying condition. Provision must be made for the satisfactory care of the patient's needs. Mild cases can be cared for in the home but the more severe case requiring watchful supervision, extensive nursing care or other facilities of a specialized nature will require institutional care.

The patient should be kept from an empty invalidism. Activities of both an avocational and a vocational nature, regulated to suit

his tolerance, should be encouraged. Deterioration is delayed when there is a stimulation of social, recreational and other contacts to motivate the patient to the fullest utilization of his capacities. He should, of course, be freed from the burden of responsibilities with the handling of his affairs transferred to a suitable person. The particular lapses in judgment and behavior which threaten as enumerated above should be called to his family's attention so that they do not procrastinate too long in providing the necessary safeguards. It must also be remembered that a greater or lesser degree of physical disability is present in most cases so that the limits of permissible exertion must be individually perscribed. Diet and elimination must be watched in all cases. Because of the many different symptoms which may develop a number of special medical and nursing techniques have a place in the care of divers patients.

III. Conclusion

There are in addition to the four types considered in this chapter other psychotic conditions which present similar problems. Alzheimer's disease, or pre-senile psychosis, a condition developing rather rapidly at about age 50, and Pick's disease involving circumscribed areas of atrophy in the brain are two of these. Other organic conditions, certain brain tumors for example, have mental sequelae which dictate management policies similar to those already outlined.

Some readers will desire further elaboration of areas of individual interest. The bibliography has been selected as a guide to further reading for those who wish to consider in more technical detail the problems of theoretical psychological considerations, medical and nursing management and pathological anatomy.

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PSYCHOPATHIC
PERSONALITY

By

NORMAN Q. BRILL, M.D. Professor of Neurology

and

JOHN H. BAIRD, M.D., Associate in Clinical Psychiatry
Georgetown University Medical School, Washington, D. C.

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WILLIAM D. BRILL, M.D., Professor of Psychiatry

JOHN H. KATZ, M.D., Assistant in Clinical Psychiatry

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Chapter XVIII

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NORMAN Q. BRILL, M.D.

Professor of Neurology

and

JOHN H. BAIRD, M.D., Associate in Clinical Psychiatry

Georgetown University Medical School, Washington, D. C.

I. Introduction

The term "Psychopathic Personality" unfortunately has acquired the function of a wastebasket. There is a tendency to include under it those cases that do not clearly fit into the category of psychoses or psychoneuroses. The diagnosis is often made by exclusion rather than by the presence of specific criteria. By some, the term is applied only to the antisocial individual, whereas by others it has much broader application. The term is frequently used in the abbreviated form "Psychopath" which corresponds more to name calling than to diagnosing.

The lack of uniformity in the application of the criteria of psychiatric disorders, which is particularly marked in the "psychopathies," is complicated by the frequent occurrence of mixed syndromes. At times an individual with a psychopathic personality has, or develops, an associated psychoneurotic or psychotic disorder, and individuals with psychoneurotic or psychotic disorders not uncommonly give evidence of underlying personality disorders.

Because of the tendency in medicine to classify disorders as one

thing or another, cases with mixed symptomatology were apt to be given just one diagnosis which many times was only a poor approximation of the actual condition. This inevitably led to certain difficulties.

In private practice of psychiatry, the formal diagnosis made little difference as long as psychotic individuals were recognized and hospitalized if necessary. However, in situations where a diagnosis was immediately connected with medico-legal implications, such as in the military services, the Veterans Administration and in insurance work, the diagnosis took on great importance. This, in itself, was apt to influence the physician in making a diagnosis. It is common knowledge that direct pressure has often been exerted on physicians to make one diagnosis instead of another because of the advantages or disadvantages that were involved. The military services, the Veterans Administration and insurance companies are constantly being appealed to for "administrative" changes in diagnosis. The type of discharge that a soldier or sailor received from the services, and whether or not compensation was to be granted, depended on the diagnosis that was made. A diagnosis of psychoneurosis might lead to a medical discharge and/or compensation, whereas a diagnosis of psychopathic personality was apt to lead to an administrative discharge and no compensation. Unfortunately this was not all that was involved. The individual with a psychoneurosis was looked upon as a "sick" individual, while the person with a "psychopathic personality" was considered a bad or inadequate individual. The psychoneurotic needed treatment, in contrast to the psychopath about whom there was the widespread feeling that little could be done (or should be done). His personality and behavioral difficulties were often looked upon as either some hereditary defect like mental deficiency, or the irreversible results of a defective environment. Consequently therapy was not emphasized and often discouraged. Since most often the problem is one of Psychopathic

Personality versus Psychoneurosis, an attempt to define more adequately the similarities and differences, would appear to be worthwhile.

II. Definition

A review of the various descriptions of a psychopath in current psychiatric textbooks suggests that all individuals with socially unacceptable or obnoxious behavior who are not psychotic are placed in this group. Criminals, swindlers, hoboes, bums, sexual perverts, drug addicts, pyromaniacs, kleptomaniacs, liars, alcoholics, and, in general, those who do not abide by the moral code of the culture, are all included under the same general heading.

Current textbooks ascribe these behavioral characteristics to the "typical" psychopath:- Lack persistence of effort; changeable and fickle; seem to fail to profit from experience and repeatedly get into the same trouble; they live largely for the moment and seem not to look ahead; apt to live active eventful lives; generally unreliable and impulsive; apt to be superficially likeable, attractive and beguiling at the beginning of an acquaintance, but generally disappointing or hurting to others in the end; apt to manifest diffuse and diverse sexual activity; come into conflict with authority and do not tolerate restriction easily; apt to be adventurous and unscrupulous and do not consider the rights of others; lack of goal; fail to hold jobs for any length of time; irresponsible personally and financially; inconsiderate; tend to exaggerate, monopolize and dramatize; impaired sense of honesty, truthfulness, fairness and justice; tendency to overindulge in alcohol or drugs; apt to associate with others like himself.

His personality is described in varying combinations of the following attributes:- Egocentric or eccentric; immature - excitable - quarrelsome - abide by childhood standards of conduct; seemingly intelligent; determined to get own way, irrespective of cost; judgment is defective; seems to be conscienceless—no sense of

guilt in relationship to misbehavior; feeling is apt to be superficial; very little overt anxiety, little responsiveness to kindness or consideration; project the blame for their misfortunes on others; impaired ability for object love; they live on the principle that pleasure is the chief goal in life.

This description would seem to apply only to the aggressive or anti-social psychopath and not to the wide variety of personality and behavior disorders which cannot be included in the category of psychoneurotic or psychotic reactions and which have, therefore, been included under the category of psychopathic personality.

There are the large number of individuals of pathological personality types who show very little of the aggressiveness and irresponsibility of the "classical" psychopath. They are the ones with schizoid, paranoid, cyclothymic and inadequate personalities. Sexual deviates, whether or not they possess the characteristics of the antisocial psychopath, tend to be routinely included along with them. Individuals whose outstanding manifestations of psychological difficulty are emotional immaturity of one kind or another are also included under the heading of psychopathic personality, though they present only minor deviations and none of the other characteristics of the so-called typical psychopath. These inconsistencies have been recognized for a long time and there have been many attempts to devise better classifications of the various types of psychopathic personalities. Some have been based on the outstanding behavioral abnormality, some on the outstanding personality deviation and some on a combination of both.

The present Standard Nomenclature divides Psychopathic Personalities into three major types:

Those with Pathological Sexuality;

Those with Pathological Emotionality; and

Those with Asocial or Amoral Trends.

A fourth group of "mixed types" is also included.

The British still use the term "Moral Deficiency," for the entire group.

III. Etiology

For a long time individuals with psychopathic personalities were thought to be products of a defective heredity. They were referred to as "constitutional psychopaths," the implication being that a certain emotional constitution (in contrast to physical constitution) had been present from birth. They were considered along with the mental defectives, but looked upon as having a moral deficiency rather than an intellectual deficiency. It was believed that little or nothing could be done to alter the personality defect and that the best one could hope for in these cases was to keep them out of trouble or jail, by special supervision or discipline.

The sociologists made frequent reference to the families with high incidences of mental deficiency, insanity, psychopathic personalities, criminals, alcoholics and prostitutes, as if to prove that all of these conditions stemmed from a common trunk which had a rotten core.

It is not unusual to find such concepts in modern textbooks of psychiatry and to hear doctors, including psychiatrists, voicing these same ideas. Such thinking is consistent with the long outmoded theory that all mental and emotional disorders are hereditary (or genogenic) in origin. The custodial approach to the care of such patients was consistent with that philosophy.

With the beginning of more intensive study of these individuals the concept of environmental influence was developed. The possibility was considered that a person raised in a "psychopathic environment" might become a social or a psychiatric problem as a result of mere exposure and that there was no need to resort to a theory of heredity. This progressive step led to the attempts to provide "corrective environments" at least to the young psychopath

in the hope that adjustment would come about through "setting the right example." In many instances, however, environmental manipulation and training were complete failures. The antisocial individual, despite his seemingly sincere effort to reform, continued to be antisocial. The schizoid individual, despite his great desire to be otherwise, generally continued to be withdrawn and seclusive, and the oversuspicious or emotionally labile individual showed no fundamental change in his reactions despite his well-meaning efforts and those of his would-be-helpers. ^a

As psychiatrists in increasing numbers became interested in the dynamics of emotional disorders and began to study "psychopaths" from this standpoint, a better understanding of the etiology was possible. It was seen that there were psychogenic factors and mental mechanisms present which were in many instances no different from those seen in the psychoneuroses.

These were outlined very well by Franz Alexander¹ in his description of the "neurotic character." Granting the presence of some constitutional factor, Alexander explains the behavior of the antisocial psychopath as a combination of the direct expression of unconscious instinctual impulses and of self-punishment arising from the unconscious rejection of these same impulses. While the antisocial psychopath actualizes his world of phantasy, implicating his environment in the gratification of his urges, he seems to bring failure to himself with as much consistency.

There is a conscience or super ego in the antisocial psychopath, but it is weak and defective. Consequently there is some guilt in connection with the expression of id impulses which are not acceptable to the ego and to society. This element of *guilt* then gives rise to the need (and seeking) for self-punishment to allay the guilt which manifests itself in the antisocial psychopath in unexpected ways. At the peak of successful activity, some seemingly foolish act which is quite inconsistent with the individual's intelligence and past performance will undo the success for

example, the stealing of an article of little value and of no use to the individual, which is certain to result in detection and punishment, following a career of very successful and gainful larceny. It is remindful of the individual who cannot stand success and of the child who knowingly doing something wrong, feels impelled to continue until he is suddenly and precipitously stopped by an irritated parent. In so many instances, the trouble that the antisocial psychopath gets into cannot be explained merely on the basis of reality catching up with a person who has been seeking pleasure without thought of the consequences. The foolish, pointless acts such as a bigamist inviting attention to his bigamy so that he will be detected, instead of exerting every effort to conceal it, or the clergyman, who generally chose the time for a vestry meeting as the time to get drunk, so that he could get into trouble with the bishop, are more than just thoughtless behavior or coincidence. The pattern repeats itself and can have no other motive than "getting into trouble." It is because of this that Alexander postulates the psychogenic nature of the disorder and the presence of conflict between two parts of the personality. (Alexander points out that those who fail to show this unconscious moral reaction should be considered as a separate group—the true criminal.)

The dynamics of the antisocial psychopath center upon his defective ego and his defective super ego. In the development of his personality the basic realities were not well established and the conscience is small or warped. The irrational behavior of the psychopath resembles in some respects obsessional behavior with the underlying impulse appearing as a more or less rational act rather than in a symbolic way.

Similarly the other types of psychopathic personalities—the schizoid, paranoid, cyclothymic and inadequate, the sexual deviate and the immature individual (and even the "normal" individual with his minor personality deviations) can be presumed to be reacting to unconscious conflicts in their characteristic patterns,

with the personality or behavioral disorder representing their solutions. This group of individuals with personality disorders, varying widely in their manifestations and severity, probably constitutes the most poorly studied, but the largest single group of psychiatric disorders.

In a certain number of individuals with psychopathic personalities, the deviation is probably due to organic brain disease. For a long time, severe personality or behavior disorders have been recognized as a sequel of encephalitis or as a manifestation of epilepsy. Recent investigations of the electrical potentials of the brain have uncovered epileptic-like and other types of dysrhythmias in both children and adults with pronounced behavioral abnormalities where there was no other clinical evidence of epilepsy or other brain disease.

Studies in children reveal a high incidence of abnormal electroencephalograms in the more serious types of behavior disorders, but the actual significance of the dysrhythmias is not yet fully understood. Furthermore, behavior in some of the children has been favorably influenced by medication.

It may be that as more highly refined techniques of demonstrating organic brain diseases are developed that more instances of psychopathic behavior will be explainable on an organic basis. However, at the present time it appears that a psychodynamic approach to the problem of personality development and to the source and method of expression of emotional conflicts will be more fruitful and productive in the understanding and treatment of the majority of these disorders. No doubt there is some constitutional factor underlying and shaping the particular type of response, but it seems quite clear that it is not all constitution.

Environmental influences are certainly important, and it is probable that in some instances behavioral abnormality may be purely the manifestation of a defective environment. The so-called normal criminal may fit in this group. The development of the

super ego or conscience is intimately related to the home and community culture and to parental influences, and defects in these spheres will tend to produce defects in the super ego and predispose to the development of a psychopathic personality.

Rodgers² formulated an interesting hypothesis to explain psychopathic behavior. Assuming that it was the result of intrapsychic conflict, he looked upon its manifestations as an attempt to maintain homeostasis, or as a means of controlling anxiety and restoring dynamic equilibrium.

He studied intensively a group of 50 psychopaths who were confined at the United States Naval Disciplinary Barracks, Portsmouth, N. H. He compared the relative incidence of neurotic (autoplastic)* traits and behavior (alloplastic)* disorders at different age periods in each of the patients' lives. Under neurotic traits he included dyspepsia, excessive or finicky appetite, constipation, diarrhea, dyspnea, asthenia, excessive fatigue, muscular pains, cardiac palpitation, anxieties, fears, phobias, nightmares, insomnia, somnambulism, somnilquism, enuresis, urinary frequency, dysuria, nail biting, headaches, stuttering, tics, abnormal mood swings and hysterical conversions. The behavior disorders were grouped under three headings;— against property (acquisitive and destructive), against person and socially negative (truancy, vagrancy, etc.).

He found a history of high incidence of neurotic traits in his patients during the first five years of life, which gradually fell off between the fifth and eighteenth year, with a secondary rise from then on. On the other hand the incidence of behavior disorder rose gradually to a peak at the age of 16, after which it remained fairly constant.

* Autos=self; a'los=other. Hence the terms, autoplastic and alloplastic. Autoplastic refers to the gratification of instinctual impulses within the individual himself, i.e., by the development of a symptom. Alloplastic refers to the gratification of instinctual impulses outside the individual through the implication of the environment. It therefore involves visible behavior.

In dividing the group into those with previous prison offenses and those without prison offenses, he found that there was a higher incidence of somatization reactions in those without prison offenses, whereas symptoms indicative of free floating anxiety were as frequent and sometimes more frequent in the group with prison offenses.

His figures indicate that the most rapid decrease in neurotic traits and the most rapid increase in alloplastic traits occur between the ages of five and ten, the latency period of psychosexual development. He points out that it is at the beginning of this period that the infantile erotic desires reach a climax. During this period the conscience or super ego develops by identification with the standards of social conduct of parents or parent surrogates. It is during this time that the child's inner conscience normally begins to contest instinctual urges previously inhibited only from without. A poor cultural background, the absence of any adequate parent figure, or a defective nervous system may easily interfere with the super ego development and facilitate the continuation of infantile behavior patterns. Rodgers suggests that the remission of neurotic traits as behavior disorders develop is strongly suggestive of a direct causal relationship. (i.e., anxiety). The symptoms, whether neurotic or behavioral, occur in response to certain environmental or biological pressures. In other words, every individual is constantly struggling to maintain a state of peace within himself and in relation to the outside world (homeostasis). The presence of unconscious impulses which are unacceptable to the individual (or to society) produces anxiety and discomfort within the individual. This anxiety may be handled by one of the many automatic mechanisms which are seen in everyone: repression, sublimation, reaction formation, projection, etc. In the psychoneurotic, it may be handled by the development of a neurotic symptom, which then becomes a defense against anxiety and a means of preserving homeostasis. In the psychopath, the anxiety often cannot be dealt

with by these mechanisms because of the increased power of the id impulses, which have from an early age not been restrained and the defective ego and conscience. Relief from anxiety can, therefore, be obtained only by the direct expression of the impulse. Rodgers' hypothesis, therefore, is fundamentally the same as Alexander's.

He explains the secondary rise in neurotic symptoms of the adolescent as the result of an increase in anxiety which occurs with the loss of the protection of the home and with the increasing demands of reality, and which is accompanied by some increase in the repressive forces of the ego.

IV. Psychopathic Personality vs. Psychoneurosis

From the etiological standpoint, there seems to be certain features in common to both conditions. (In addition there are probably constitutional factors in all individuals with psychiatric disorders.) Excluding those cases where psychopathic reactions may be attributable directly to organic brain disease or trauma, psychogenic factors both endogenous and exogenous are present in the psychopath which in many instances are similar to and even identical with those encountered in the psychoneuroses. In both there is a decreased ability on the part of the individual to deal with fundamental impulses in a way that maintains homeostasis. In other words, the three main factors which in varying degrees contribute to the development of psychoneurosis, namely: heredity, early life experiences and more current difficulties to which an individual is exposed, operate to produce a psychopathic state. Both the psychoneurotic and the psychopath are concerned with finding gratification for their needs and desires though they pursue different courses in attempting to find such satisfaction.

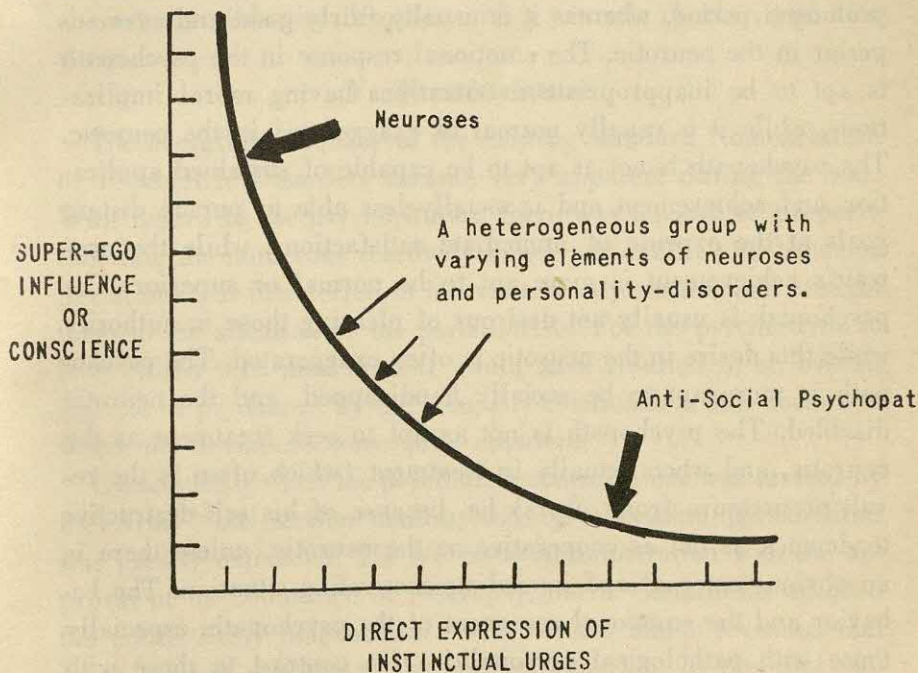
However, there are certain differences. In the antisocial psychopath, the super ego or conscience (the higher inhibitory control force) is weak, whereas, in the neurotic it is normal or even

over-scrupulous in its control over the ego. In the former there has been an inability to develop adequate parental identifications or emotional attachments, while in the latter, the identifications and emotional attachments to the parents were present but disturbed. In the antisocial psychopath, unconscious tendencies are acted out in the major events of his life. The instinctual impulses and phantasies are directly expressed as behavior, whereas in the neurotic they are indirectly and symbolically expressed as symptoms (psychological or psychosomatic) which represent defenses against these impulses. The behavior of the psychopath is apt to be unrelated to stress, while the neurotic difficulty is apt to be related, even if superficially, to external pressures. There is a certain "consistency" in the behavior of the psychopath, a life-long pattern without remissions, while in the neurotic, symptoms are much more apt to be episodic and to fluctuate in intensity. The social behavior of the psychopath is more apt to be *peculiar, odd, and aggressive*, whereas, in the neurotic it is usually well controlled or even too rigidly controlled. While there is probably a constitutional defect in both conditions, it is of a different variety or type.

Alexander³ has compared a healthy personality to an ideal democratic state which solves conflicting interests through mediation and compromise, and a neurotic personality to an autocratic state impoverished in initiative and governed by anxiety and coercion. He states that the central dynamic factor in neurosis is repression and with it those extensive defense measures (symptoms) by which the central government, the ego, tries to keep all the unacceptable impulses out of its territory. By the same analogy, one might liken the antisocial psychopathic personality to a country without a government of any kind, where insecurity is the rule and where all the inhabitants have failed to grow up to any sense of reality, having remained at an immature level and with very little hope of improvement of their state because of a lack of any guiding hand.

What has been said of the etiology of the antisocial psychopath would apply to the other varieties of psychopathies. In each instance the "symptoms" are the expression of the unconscious impulses—modified to a greater or lesser degree—depending on the extent to which the controlling influence of the super ego has developed.

This is expressed graphically in an over simplified fashion in the figure below where only two of the elements of the personality are considered.



(Explanation of figure.)

Considering just two elements of the personality, the id and the super ego, the greater the super ego, the less will be the direct expression of instinctual urges. Conversely the smaller the super ego and the greater the force of the id impulses, the greater will be the direct expression of instinctual urges.

The antisocial psychopath with a defective (small) super ego, is apt to express his instinctual urges directly. The neurotic with a well developed super ego, shows relatively little direct expression of instinctual urges. In between the two extremes there are a large number of individuals who manifest both neurotic and psychopathic traits.

From the clinical standpoint, the antisocial psychopath is fundamentally a lone wolf, showing a tendency not to develop deep emotional relationships with others, whereas the neurotic tends to seek relationships with others but in a dependent way. Anxiety in its various expressions, both subjective and objective, is apt to be much less prominent in the psychopath than in the psychoneurotic. Somatic complaints, while frequent in the neurotic, are comparatively infrequent in the psychopath. The social and industrial adjustment in the psychopath is often impaired over a prolonged period, whereas it is usually fairly good and even superior in the neurotic. The emotional response in the psychopath is apt to be inappropriate in situations having moral implications, while it is usually normal or exaggerated in the neurotic. The psychopath is not as apt to be capable of sustained application and achievement and is usually less able to pursue distant goals at the expense of immediate satisfactions, while the neurotic's achievement is more apt to be normal or superior. The psychopath is usually not desirous of pleasing those in authority while this desire in the neurotic is often exaggerated. The psychopath is more apt to be socially handicapped, and the neurotic disabled. The psychopath is not as apt to seek treatment as the neurotic, and when actually in treatment (which often is the result of pressure from others) he, because of his self-destructive tendencies, is not as cooperative as the neurotic, unless there is an obvious external and immediate motivating situation. The behavior and the emotional responses of the psychopath, especially those with pathological personalities (in contrast to those with immaturity reactions), approximate psychotic dimensions much more than does the neurotic.

Clinically, the differentiation between a typical psychoneurotic showing both subjective and objective symptoms and one of the pathological personality types, is at once apparent. However, it is sometimes quite difficult to distinguish between one of the im-

maturity reactions and psychoneurosis. The major features which differentiate these reactions from psychoneurotic disorders are the recurrent transitory appearances of symptoms of anxiety, generally in direct relationship to a minor stressful situation, ordinarily not incapacitating and with freedom from neurotic-like symptoms in the absence of stress. Moreover, it must be kept in mind that there is considerable overlapping of the manifestations of the various types of character and behavior disorders and also that there are cases with mixed manifestations, showing an underlying character or behavior disorder with a neurotic overlay, and vice versa.

V. Nomenclature

The overall inadequacy of the existing Standard Nomenclature of Psychiatric Disorders became very apparent during the war. With regard to the psychopathies, there was no way of properly labelling the numerous relatively minor personality and behavior deviations that interfered in individuals' adjustments and brought them to the attention of the psychiatrists. For the psychiatrists to have called such men normal would have resulted in an overall distrust of psychiatry by the company commanders and doctors to whom the deviations were quite apparent.

Consequently when the psychiatric nomenclature was revised by the Army⁴ the section dealing with psychopathic personalities was greatly expanded. The Veterans Administration with the approval of its Committee of Neuropsychiatric Consultants adopted the entire Army nomenclature with certain minor revisions that made it more suitable to the civilian situation. In this new Nomenclature of Psychiatric Disorders⁵ the term "character and behavior disorders" is used in lieu of the old term psychopathic personality, which is at best confusing.

The entire section on the *Character and Behavior Disorders* is included here because it is believed to be the best functional classification yet devised for this group of cases.

Character and Behavior Disorders. Such disorders are characterized by developmental defects or pathological trends in the personality structure, with minimal subjective anxiety, and little or no sense of distress. In most instances, the disorder is manifested by a life-long pattern of action or behavior ("Acting out"), rather than by mental or emotional symptoms. Occasionally, organic disease of the brain will produce the clinical picture of a character or behavior disorder, such as, chronic epidemic encephalitis, head injury, epilepsy, etc. (This latter group of cases is included under the organic mental syndromes rather than in the primary character and behavior disorders.)

a. *Pathological personality types.* The maladjustment of many individuals is evidenced in abnormal life-long behavior patterns. Such individuals are frequently described as personality types. In the evolution of psychoneuroses or psychoses, these types may be likened to abortive stages. They do not usually progress to the stage of a psychosis, nor do they justify a diagnosis of any type of neurosis or psychosis, although they may show some of the characteristics of both. They represent borderline adjustment states. The following types of pathological personality types will be differentiated.

- (1) *Schizoid personality.* Such individuals react with unsociability, seclusiveness, seriousmindedness, nomadism, and often with eccentricity.
- (2) *Paranoid personality.* Such individuals are characterized by many traits of the schizoid personality, coupled with a conspicuous trend to utilize a projection mechanism, expressed by suspiciousness, envy, extreme jealousy and stubbornness.
- (3) *Cyclothymic personality.* Such individuals are characterized by frequently alternating moods of elation and sadness, stimulated apparently by internal factors rather than by external events. The patient may oc-

asionally be either persistently euphoric or depressed, without falsification or distortion of reality. The diagnosis should specify, if possible, whether hypomanic, depressed, or alternating.

- (4) *Inadequate personality*. Such individuals are characterized by inadequate response to intellectual, emotional, social, and physical demands. They are neither physically nor mentally grossly deficient on examination, but they do show inadaptability, ineptness, poor judgment and social incompatibility.

- (5) *Antisocial personality*. This term refers to chronically antisocial individuals who, despite a normal moral background, are always in trouble, profiting neither from experience nor punishment, and maintaining no real loyalties to any person, group or code. They manifest disregard for social codes and often come in conflict with them by becoming gangsters, vagabonds, racketeers and prostitutes. Many such individuals are to be regarded as the normal product of a life-long abnormal environment. This term includes most cases formerly designated as "Psychopathic personality" and "Constitutional Psychopathic State," with asocial amoral, and anti-social trends.

- (6) *Sexual deviate*. These conditions are often a symptom complex, seen in more extensive syndromes as schizophrenic and obsessional reactions.

The term includes most of the cases formerly classed as "Psychopathic personality, with pathologic sexuality."

The diagnosis will state whether overt or latent, and specify the specific type of the pathologic behavior, such as homosexuality, transvestism, pedophilia, fetishism, and sexual sadism (including rape, sexual assault, mutilation).

- b. *Immaturity reactions*. This category applies to adults who are unable to maintain their emotional equilibrium and

independence under minor or major stress, because of deficiencies in emotional development. Some individuals are classed in this group because their behavior disturbance is based on a fixation of certain character patterns; others because their behavior is a regressive reaction due to severe stress. The classification will be applied only to such character and behavior disorders in which the neurotic features (such as anxiety, conversion, phobia, etc.) are not prominent and only the basic personality development, and not anxiety, is the crucial distinguishing factor. Evidence of physical immaturity may or may not be present. The diagnosis should report the specific immaturity reaction as defined below:

- (1) *Emotional instability reaction.* In this reaction the individual reacts with excitability and ineffectiveness when confronted with minor stress. His judgment may be undependable under stress, and his relationship to other people is continuously fraught with fluctuating emotional attitudes, because of strong and poorly controlled hostility, guilt, and anxiety which require quick mobilization of defense for the protection of the ego. This term is synonymous with the former diagnosis of "Psychopathic personality, with emotional instability."
- (2) *Passive-dependency reaction.* This reaction is characterized by helplessness, indecisiveness, and a tendency to cling to others. The clinical picture in such cases is often associated with an anxiety reaction which is typically psychoneurotic. There is a predominant child-parent relationship in such reactions.
- (3) *Passive-aggressive reaction.* This aggressiveness is expressed in such reactions by passive measures, such as pouting, stubbornness, procrastination, inefficiency, and passive obstructionism.
- (4) *Aggressive reaction.* A persistent reaction to frustra-

tion with irritability, temper tantrums, and destructive behavior, is the dominant factor in such cases. A specific variety of this reaction is a morbid or pathological resentment. Below the surface, there is usually evident in such cases a deep dependency. The term does not apply to cases more accurately described by the term "Antisocial personality."

- (5) *Immaturity with symptomatic "habit" reaction.* This category is useful in occasional situations where a specific symptom is the single outstanding expression of the psychopathology. These terms should not be used as diagnoses, however, when the symptoms are associated with or are secondary to organic illnesses and defects or to other psychiatric disorders or reactions. Thus, for example, the diagnosis "Immaturity with symptomatic habit reaction; speech disorder," would be used to describe certain disturbances in speech in which there are insufficient other symptoms to justify any other definite diagnosis. This type of speech disturbance often develops in childhood. It would not be used for speech impairment that was a temporary symptom of conversion hysteria or that was the result of any organic disease or defect. The diagnosis should specify the particular "habit" reaction, as for instance, enuresis, speech disorder, stammering, stuttering, chronic, excessive masturbation, etc.

VI. Social and Legal Aspects

The psychopath, particularly of the antisocial variety, constitutes a social problem as well as a psychiatric problem. In the past he has been approached from the punitive standpoint rather than from the therapeutic standpoint. To be sure, the more progressive corrective institutions have made some effort to rehabilitate psychopathic offenders. However, for the most part they have been looked upon as the "black sheep" as "incorrigibles" and,

because of the usual lack of responsiveness to therapy (such as has been given), as hopeless. The antisocial psychopath when not confined, was either not apt to seek therapy or if brought to therapy, was apt to be unreliable and unresponsive. Usually he was apt not to be offered therapy except in a few instances where trained personnel were available and interested.

One of the most encouraging experiences along these lines was in the Army Rehabilitation Centers where group psychotherapy was included in the daily program of the prisoners—many of whom were antisocial psychopaths who had been sentenced to dishonorable discharges for various offenses. The insight into their own behavior (or misbehavior) which many of them received from the group psychotherapy sessions was amazing, and was reflected by improvement in behavior which, by follow-up studies, was lasting. The Army Rehabilitation Centers were established for the purpose of salvaging general prisoners for further duty and where this objective was maintained as the primary goal, dramatic results were obtained. Unfortunately, in only a relatively few civilian penal institutions has psychotherapy been included in the rehabilitation program (and in only relatively few is there any rehabilitation program at all).

There is an increasing tendency to look upon the psychopath and the criminal as socially *sick* individuals rather than as just *bad* individuals. They are psychologically sick and treatment associated with incentive (as in the Army Rehabilitation Centers where sentences could be remitted) should be the primary goal of confinement. Many psychiatrists, psychologists and criminologists have already stressed this need and proposed that length of confinement be determined not only by the nature of the act or crime, but by the prisoner's emotional state. More trained personnel will have to be available and concrete results demonstrated before the attitude of society is changed and the laws modified.

In many states, legal provision is made for the commitment of

sexual psychopaths to psychiatric hospitals in lieu of specific sentences for specific offenses. So far it has not been possible to commit for treatment other types of psychopaths unless their behavioral abnormalities have been sufficiently pronounced to be classified as psychotic. In many instances criminal offenses could have been predicted and prevented by hospitalization if it had been provided for legally.

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THE
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OF
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By

RALPH R. BROWN, Ph.D., Psychologist
United Industrial Service, Cincinnati, Ohio

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RALPH A. BROWN, Ph.D., Psychologist
United Industrial Services Corporation, 1914

Chapter XIX

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By RALPH R. BROWN, Ph.D., Psychologist

United Industrial Service, Cincinnati, Ohio

I. Introduction

For ages reaching back into antiquity man has used the juices of herbs and roots to increase his physical and mental well-being. Sumerians derived pleasure and relief from pain from the juice of the poppy more than 5,000 years before the birth of Christianity. Before the time of written history the Chinese were using the flowering tops of hemp plants to produce psychic thrills identical to those enjoyed by millions today through marihuana and bhang. For generations the natives of Peru and Bolivia have chewed the leaves of the coca tree for stimulation and for the apparent or actual increase in efficiency associated with cocaine administration.

The experimental psychologist is interested in drugs from the standpoint of control over mood, emotion, and efficiency. By the use of drugs he can duplicate the psychological correlates of fear, anger, and other emotions. He can depress the "will," produce sleep, alter motivation, facilitate or retard the learning process. Thus by altering the functions of organs and cells, the psychologist can approach the problem of human behavior more directly and more specifically than would be possible from any other approaches.

The social psychologist is interested in drugs through his desire to understand the etiology of social problems arising from wide-

spread addiction and "abuse" of drugs. The origin of mores concerning the use of drugs is not clearly understood. It is generally considered "natural" and "right" to use drugs for the promotion of physical well-being and for the relief of pain. With the exception of certain drugs, it is not considered "natural" or "right" to use drugs for the promotion of emotional well-being. Coffee and tea are generally accepted as stimulants in this country, but cocaine or even benzedrine is disapproved. Alcohol is generally socially acceptable as a depressant, but morphine, marihuana, and the barbiturates are castigated. The fact that alcohol is probably more physically damaging than morphine, marihuana, or cocaine and yet enjoys such widespread social recognition is difficult to explain.

The clinical psychologist is interested in drugs because of the light which drug action may shed upon behavior disorders and because drugs may be used to promote rapport and break down resistances. The use of pentathol and other drugs of the barbituric acid group has gained acceptance as a clinical tool for reaching below the surface of consciousness. The use of such drugs as insulin and metrazol for the treatment of schizophrenia and other mental disorders is of interest to the clinical psychologist, as well as such drugs as the recently described "methapon" which is claimed to relieve the distress of withdrawal from morphine dependence.

It is unfortunate, although understandable, that psychologists have not used drugs to full advantage in the pursuit of their science. Psychology has long been divorced from medicine and pharmacology. Relatively few psychologists have the background of training in biochemistry and neurophysiology necessary to conduct fundamental experiments in the field of drug action. As far back as 1899, Kraepelin,¹⁵ at that time a student of Wundt, studied the effects of alcohol on mental efficiency. Today Kraepelin is best known for his classification of mental illnesses. His

work in the field of experimental psychology has generally been forgotten. Since that time effects of drugs have been studied by Rivers (1908), Dodge and Benedict (1915),⁵ Hollingworth on Caffein (1912),⁹ and Hull (tobacco, 1924),¹² Hull contributed significantly to the techniques for masking the stimulus but unfortunately few workers have built upon his foundation. Other early workers in the field of drug effects were McDougal,^{18 19} W. R. Miles,²⁰ and Poffenberger.²²

A further complicating factor in research on the effects of drugs is our lack of knowledge concerning the manner by which various drugs exert their effects on muscles, nerves, and glands. For example, there is no satisfactory explanation for the fact that cocaine potentiates both excitatory and inhibitory responses of muscles and glands to adrenergic nerve impulses. The actions of morphine are not clearly understood, particularly tolerance and dependence. Many drugs have direct or indirect actions which cannot be explained by current theories. Unless the experimental psychologist knows *how* a drug exerts its effect as well as *what* effects are produced, the significance of his findings for general theory are limited.

In the present chapter it is not the purpose of the writer to present a compilation of the miscellaneous facts concerning the actions of various drugs which have been presented in the literature. The purpose of this chapter will better be served by discussing the fundamental significance of drug research and outlining and discussing the major problems in the field. Problems of classification and a brief summary of the effects of the more important drugs will be presented.

II. Mechanisms of Drug Action:

Drugs cannot impart to a cell or tissue functions which are not inherent in its structure. Drugs can only inhibit or potentiate the actions of cells or tissues. The manner in which drugs produce

their actions is highly complex and is unknown in the case of many drugs. Most drugs are selective in the sense of affecting only a particular tissue. For example, drugs affecting the autonomic nervous system may roughly be classified as sympathetic and parasympathetic types. Drugs may directly stimulate structures enervated by adrenergic nerves (epinephrine). There are drugs which inhibit structures enervated by adrenergic nerves (ergotamine). There are drugs which stimulate structures enervated by cholinergic nerves and those which exert a parasympathicomimetic effect through inhibiting the action of Cholinesterase, the chemical which blocks the action of Acetylcholine (Prostigmine or Physostigmine).

Drugs may affect the nuclei in the cortical or sub-cortical areas; they may affect synaptic transmission; they may affect the effector cells; they may inhibit the inhibitors; they may sensitize the organs; they may lower the threshold of excitability of organs or ganglia; they may act directly on muscles and glands.

III. Problems of Experimental Control and Interpretation:

A. Individual Differences

In addition to the neurophysiological problems, there are other factors which confuse, irritate, and sometimes fascinate the psychologist searching for facts and understanding regarding drug action. One of these problems is that of individual differences—unexplained variations in human reaction to a common stimulus. For example, morphine is a central nervous system depressant, but every physician is familiar with the so-called 'cat' reaction to this drug (said to occur more frequently in women than in men) in which morphine produces an exciting rather than a depressant effect. Wide variations in effect are also found in marihuana and cocaine, although it is probable that the variations in reaction are also due to differences in rates of drug absorption or some other controllable factor.

B. Animal Studies

Although animal studies have contributed significantly to our knowledge of human behavior, nevertheless even the findings on such "higher" animals as the chimpanzee cannot always be considered as applicable to the human species. For example, the chimpanzee can be "addicted" to morphine by repeated injection of the drug to the extent that he will voluntarily position himself for hypodermic injection.²⁶ There are gross differences in addiction between man and the chimpanzee, however, as evidenced by the fact that during withdrawal from addiction the body temperature of the chimpanzee drops whereas in man it regularly shows a rise. Furthermore, the chimpanzee manifests no interest in the drug after two weeks or less, whereas the human addict's desire remains for years. The experimental psychologist must check all hypotheses derived from animal studies against findings in the human species.

C. Masking the Stimulus

It is well known that suggestion can significantly alter the type and extent of human reaction. Psychologists have been aware of the role which suggestion may play in drug studies, although most attempts at controlling this variable have been inadequate. For example, it is doubtful if subjects would fail to recognize the difference between orange juice alone and orange juice mixed with alcohol. The technique which Hull used in his studies on the effects of tobacco is a good example of control as far as this variable is concerned.¹² Blindfolded subjects drawing warm moist air through his specially designed pipe were generally unable to differentiate between the air and the tobacco smoke. Denicotinized cigarettes are now available as a control device.

The most effective means of masking the stimulus is by administration of the drug directly into the blood stream. A con-

tinuous flow of the drug solution may be maintained at any desired rate and concentration, with physiological saline serving as a control. By this method suggestion through taste and smell is eliminated.³

D. The Rate of Absorption and Size of Dose

Few experimental studies on the effects of drugs have adequately controlled the rate of drug absorption and many have not controlled the size of the dosage administered. The size of dose is important because small doses do not possess in lesser degree the same action as large doses. In many instances the drug effects are completely reversed. For example, small amounts of Atropine stimulate the vagus centrally and slow the heart rate, whereas larger doses increase the heart rate because of vagal inhibition. Where fundamental understanding of drug action is desired, oral administration is not recommended. The effects of oral injection of alcohol will depend upon the rate of absorption through the stomach wall, and thus the effect is subject to variation because of physical condition and structure, as well as previous diet. As indicated previously, the most effective method is continuous intravenous administration.³

E. Control Groups and Sampling Errors

In their attempts to determine the effects of drugs upon social behavior and the types of individuals who become addicted to the use of various drugs, social psychologists are faced with the extremely difficult task of finding satisfactory control groups. The average citizen may not have the time nor the inclination to subject himself to such control studies. Hospitals, penitentiaries, and college populations are not generally acceptable. Closely linked with this problem is that of selecting a representative sampling of the experimental or study group. The alcoholics, the morphine addicts, and the marihuana smokers who come to the

attention of the psychologists and psychiatrists are apt to represent a biased sampling. The percentage of regular patrons of bars and cafes which turn up in hospitals or join Alcoholics Anonymous is unknown. It is quite possible, even probable, that there are significant differences between those who break down and require treatment as compared with those who do not.

F. Adaptation and Conditioning

In long term studies of drug effects, the subjects become adapted and conditioned to both the experimental tests and to the drug effects. This is one of the most difficult variables to control. When sensory, motor, or coordination tests are made at regular intervals, there is gradual improvement through the perfection of response or fixation of the response pattern so that a high level of performance may be maintained even under strong drug influence. On the other hand, if the experimental tests are highly sensitive and are not subject to fixation through learning, then the day-to-day performance is apt to fluctuate because of daily and hourly fluctuations in physical and mental states regardless of drug effects. Tests have shown that although a subject may be intoxicated to the point of being unable to maintain his equilibrium while sitting in a chair, he may nevertheless be able to "pull himself together" sufficiently to score high on a motor coordination test.⁶ In studies on asphyxiation, Dunlap has also shown that although diplopia occurs at an early stage, the subject is able to pass ophthalmological tests for this condition until a severe stage of asphyxiation has been reached.⁶ It is not too optimistic to hope that some day we will understand the mechanism whereby such reserves of energy may be called upon to counteract the normal or expected physiological effects.

Adaptation and conditioning to drug effects must be given serious consideration in all experiments involving repeated administration. Tolerance develops to some degree with all drugs,

although there is a wide variation in this respect. With repeated injections of morphine, the size of the dose may be increased to ten or fifteen times the amount which would be fatal in the non-tolerant individual. On the other hand, cocaine does not appear to produce much tolerance, although even here there are instances in which addicts have taken normally fatal doses without serious consequences.

G. Attitudes and Motives

The attitude of the subject toward the experimental situation may adversely affect the results. It is almost impossible for a subject to take a neutral attitude toward alcohol, morphine, cocaine, marihuana, or tobacco. Such attitudes along with the reasons a subject may have for participating in the experiment can reflect favorably or unfavorably upon performance.

H. Control over Actions of the Subject

The results of many experimental studies have been affected by the failure to control the activities of the subjects during the period of study. In studies of morphine addiction and withdrawal, for example, the addict will frequently use ingenious methods to supply himself with the drug during periods of withdrawal. In such instances an experimenter may attribute benefits to a substitute drug without realizing that the addict is still using his drug of choice.

I. Mixed Drugs

In his "Confessions of an English Opium Eater" (1821), Thomas De Quincey wrote a description of the pleasures of opium which has become recognized as a masterpiece of thrill expression and a powerfully unfavorable social influence. Actually, the drug used by DeQuincey was a mixture of alcohol and opium, which complicates the interpretation of these report-

ed drug effects. If the experimenter is interested in fundamental drug action, then every care must be taken to maintain drug purity. On the other hand, it may happen that the experimenter is interested in a complex mixture (such as tobacco smoke), in which case the problem of purity may not be so important.

J. Classification of Drugs

The classification of drugs from the standpoint of psychology must necessarily differ from the classification given in textbooks on pharmacology. For example, cocaine is classified as a local anaesthetic from the pharmacological standpoint. From the psychological standpoint, however, it should be classified as a stimulant because of its exciting action on the cortex and because of its sympathicomimetic effects. Psychological studies in the field of drug action have been too limited in scope to allow for a complete classification from the psychological viewpoint. It is to be hoped that one day sufficient experimental work will be done in this field to enable us to present a "Textbook of Psychopharmacology."

Drugs may roughly be classified into depressant and stimulant types, and these classifications may further be divided into drugs which primarily affect the central nervous system and those which act primarily on the autonomic. Those drugs which act on autonomic effector cells may be further subdivided into sympathicomimetic, para-sympathicomimetic, autonomic blocking agents, and drugs of endocrine origin. A more complete classification would also include drugs acting on touch, temperature, pain, taste, vision, hearing, co-ordination, and even the more intangible qualities of motivation, intelligence, extroversion, etc., but this is beyond the scope of the present chapter.

K. Misinterpretation of Relationships

Correlation between factors or variables is not sufficient proof

of causation. This type of error is common to all fields of science, but it is a particularly important factor in studies on social psychology. It is undoubtedly true that an unusually high percentage of morphine addicts are criminals. This cannot be interpreted, however, to mean that morphine as such weakens the character or produces criminal behavior. The fact that morphine may cost from forty to sixty dollars an ounce and that the addict may use one or two ounces a week, along with the fact that the drug must be procured and used illegitimately, tends to drive the morphine addict into criminal behavior. Behavior produced by attitudes and laws relating to the use of a particular drug must be differentiated from behavior caused by the drug itself.

IV. Central Nervous System Depressants

The classification of drugs as central depressants is unsatisfactory from the psychological point of view for the reason that the variations in effect among these drugs are greater than the common characteristics. Such drugs as ether, alcohol, marijuana, and morphine, although classified as central depressants, differ considerably among themselves with reference to experimental and behavioral effects. A more logical and practicable classification must wait upon further experimental work, since the mechanism of cortical depression through drug action is not clear.

A number of theories have been adduced to explain the depressant action of drugs, such as the Lipoid Theory, the Surface Tension Theory, Cell Permeability Theory, Inhibition of Oxidation, and others. The Meyer-Overton theory is of interest to psychology because it demonstrates a high correlation between physico-chemical properties and depressant action. The theory states that there is a direct parallelism between affinity of an anesthetic for lipid and its depressant action. It states that the more soluble an agent is in oil and the less soluble it is in water,

the more anesthetic it will prove to be. The formula is simply stated as: solubility in fat over solubility in water. Anesthetic power increases directly with the size of this coefficient. This theory appears to work well with alcohol, chloroform, ether, and related drugs, but a number of anesthetics do not conform to the theory, such as chloral hydrate and the alkaloids.

A. Ether

Ether is the most widely used general anesthetic and as such it will be discussed here as typical of the volatile liquids, such as ether, chloroform, and the gases such as nitrous oxide. Most of the research on anesthesia has been done by physiologists and pharmacologists. For a more extensive treatment of this subject, the reader is referred to standard texts in pharmacology.

Inhalation of ether produces a series of mental changes from slight mental confusion to complete loss of consciousness. After a few deep inhalations of ether, the subject experiences feelings of unreality and disturbed consciousness. The irritating nature of the drug may produce lacrimation, rhinorrhea, and even vomiting. Feelings of suffocation are common, particularly when the "closed" method is employed. Attention and logical thinking are disturbed, speech becomes inarticulate, and the subject may experience auditory, visual, and even tactile hallucinations. Noises, buzzing sounds, and bright lights are frequently reported. The subject may feel tense, buoyant, or projected out into space.

During this initial stage the subject may lose self-control and engage in confused talking, laughing, singing, frequently tapering off into incoherent muttering. As anesthesia progresses, the cortex is completely depressed, following which the basal ganglia and cerebellum are depressed. The sensory and then the motor functions of the spinal cord are affected, and finally, if anesthesia is allowed to progress, the medulla is involved with

paralysis of respiration and autonomic functioning.

In general, the order of the depressive sequence follows inversely the phylogenetic development of nervous functioning — that is, attention and reasoning are affected in the early stages and the vital vegetative functions are the last to succumb to the effects. As the “higher” centers are blocked out, the subject may become violently excited, which is probably due to the elimination of cortical control over thalamic and hypo-thalamic functioning. There are reports of ether being used as a psychic “stimulant,” but such cases are uncommon, perhaps because of its irritant action.

B. Alcohol

Considerable amount of research has been done by social and experimental psychologists on the effects of alcohol, the reasons for taking the drug, characteristics of alcoholics and problems connected with alcoholic habituation. Alcohol is considered a cortical depressant, although some workers maintain that alcohol produces an initial stimulation which is followed by depression. The most acceptable explanation of such “stimulation” is that it results from a depression or blocking of cortical control over lower centers. Experiments by Rivers²⁴ and by Dodge and Benedict⁵ have supported the theory that alcohol is a cortical depressant. Following a review of 170 published papers on psychological experiments with alcohol, Jellinek and McFarland concluded that the effects of alcohol are purely depressant¹³. Effects on reaction time and coordination have been observed following the administration of less than one ounce of alcohol. It should be emphasized, however, that large individual variations occur, depending upon the physical characteristics and condition of the subject, habituation, and tolerance. Undoubtedly alcohol is a common cause of accidents. For example, Holcomb⁸ found that 47% of 270 drivers involved in motor accidents had

measurable amounts of alcohol in the blood as contrasted with only 12% of the general population. The percentage of alcoholic concentration in the blood has been shown to correlate significantly with laboratory tests of efficiency as well as the number of automobile accidents.

Moderate indulgence in alcohol (one to three ounces, or one to three single-shot highballs) is associated with an increase in confidence, a loss in inhibition and in fine motor control. The euphoria of the drinker is difficult to describe, but it appears to be characterized by a "wave of elation" which may warm and thrill the drinker, particularly as the alcohol first produces its effects. Under alcohol the subject is apt to be less critical of himself and others. He is frequently impressed with the profundity of his own ideas and his increased confidence in himself and his mental powers may bring financial loss in business ventures or games of chance, as well as damaging accidents to himself and others. The speaker who fortifies himself with alcohol before a public address may believe that alcohol helps him to speak with moving eloquence and he may cite favorable audience reaction as evidence of his accomplishments. There are some questions, however, as to the sobriety of the audience, and as to how much of the latter's enthusiasm is due to the lowering of their own critical sense through indulgence in alcohol.

With heavy doses of alcohol, the subject becomes lethargic and severely incoordinated. Speech becomes blurred, the eyes glazed, and the sense of pain is reduced to the point where the subject may not recognize serious physical injuries. In spite of his relative helplessness, however, his confidence is not impaired and he may insist on demonstrating his athletic prowess even though being held to keep from falling. Alcohol is frequently claimed to be an aphrodisiac, although here again evidence indicates that confidence and freedom from repression, together with social stimulation, are more involved than is any actual increase in sexual power.

Frequent indulgence in alcohol may lead to a state of habituation called chronic alcoholism. Under such conditions the subject may be impelled to drink large quantities of alcohol daily with the result that permanent physical and mental damage occurs. The daily use of alcohol in moderate amounts may produce no permanently injurious effects, although the danger of succumbing to severe chronic alcoholism is enhanced by daily drinking. Some individuals have such an affinity for alcohol that they cannot take even one or two drinks without continuing to the point of unconsciousness or severe intoxication. Other individuals can drink moderately for years and finally succumb to chronic alcoholism. In many cases it may take ten years or more to develop severe habituation to alcohol.

It is difficult to determine the physical and mental effects of chronic alcoholic indulgence, since improper diet is generally associated with heavy drinking and therefore malnutrition and vitamin deficiency are associated factors in producing gastrointestinal irritation and various degenerative changes in internal organs.

Bowman and Jellinek have indicated that a form of alcoholic addiction may develop almost immediately upon experiencing the effects of alcohol. This craving is interpreted as "psychologically" motivated rather than being based upon a psychological need. In this connection however, Richter²³ has shown that rats prefer solutions of from one to six percent alcohol over water, but apparently dislike higher concentrations. According to Bowman and Jellinek¹⁴, "secondary addiction" is the most common, developing only after prolonged and excessive drinking. Even in such cases, however, the withdrawal symptoms are not as severe as those associated with addiction to the opiates.

Studies by Manson^{46 47 48} have shown significant differences between alcoholics and non-alcoholics in a number of personality traits. He isolates seven psychoneurotic and psycho-

pathic traits which are particularly characteristic of the alcoholic. These traits are:

- (1) *Anxiety*-(An excessive number of fears, worries, feelings of insecurity and inadequacy; undue concern over health, easily fatigued).
- (2) *Depressive Fluctuations*-(Easily depressed, sadness, frequent mood swings toward depression; prone to quick disappointment).
- (3) *Emotional Sensitivity*-(Extreme emotional sensitivity with inability to make satisfactory social or emotional adjustment; extreme liability with poor defenses; touchiness).
- (4) *Resentfulness*-(Strong and bitter feelings of resentment toward society and individuals; easily irritated; carries chip on shoulder; paranoid ideas).
- (5) *Incompleteness*-(Failure to complete commonly accepted social objectives such as: education, work mastery, steady employment, marital adjustments, community participation, religion, philosophy of life; restlessness, unsteadiness, mobility, and frequent change).
- (6) *Aloneness*-(Feelings of being alone in the world, isolated, unique, unwanted, undersocialized; feeling as if there were a barrier between the individual and the world or society).
- (7) *Interpersonal Relations*-(Lack of close personal and emotional ties; poor family relations, parental rejection, unhappy childhood; lack of real friends, shallow emotional relationships).

It is recognized that there is no specific type, but rather the alcoholic shows combinations of the above traits. Dr. Manson has devised tests to measure the degree of alcoholic addiction and to identify the specific areas of maladjustment in alcoholics.

These tests are called the ALCADD TESTS (Designed to measure the degree of alcoholic addiction) and the MANSON EVALUATION (Designed to identify individuals whose behavior and personality structure indicate they were alcoholic, had serious alcoholic problems, or have the characteristics of alcoholics).

V. The Opiates

The juice of the poppy capsule has furnished medicine with its most powerful and effective means of relieving pain. The most important derivative of opium is morphine, although codeine and thebaine are well known. Heroin, Dionine, and Dilaudid are well known synthetic alkaloids which are closely associated with the natural opiate derivatives. The discussion in this section will be limited to morphine.

Social psychologists are interested in morphine because of its tremendous euphoric powers and its addicting properties. The euphoric power of this drug is such that experience with the drug may lead rapidly to addiction. Morphine addicts who have been incarcerated for a number of years because of violation of the Harrison Narcotic Law will frequently return to the drug immediately upon release. Once addicted, the addict will govern his life to conform with his morphine needs. He becomes solely concerned with the maintenance of his morphine supply, and in most cases he is prepared to sacrifice his family, his friends, and his job if they interfere with his addiction.

Small injections of morphine (5 to 10 milligrams) reduce the sensibility to pain, hunger, and general discomfort. The overall experience is one of relief from tension and feelings of well being. Pain is reduced and there is a general feeling of emotional tranquility. The subject goes into a drowsy, lethargic state, characterized by drug addicts as "going on the nod." With moderate and even small doses, morphine may produce nausea and vomiting, although frequently such vomiting is not associated

with the usual discomfort. In some humans, particularly women, excitement rather than lethargy is produced. Though the reasons for these individual differences are not established, it is probable that the reaction is associated with the removal of cortical inhibition over thalamic and hypo-thalamic functioning.

Repeated administration of morphine leads to addiction, which is characterized by tolerance and dependence. The usual clinical dose of morphine is from ten to fifteen milligrams. Sixty milligrams in the nontolerant human is generally fatal. With repeated administration of the drug, a tolerance is established which would permit many times the fatal amount to be administered. For example, in experiments on drug addiction conducted at the United States Public Health Service Hospital, Lexington, Kentucky, one subject received more than 630 milligrams seven times daily⁴. The drug appeared to have no adverse effect upon his behavior. He ate and slept well and carried on his normal activities.

The addict will generally take his drug several times a day, although experiments have shown that a mild form of dependence may be established by injections of fifteen milligrams once a week. When a strong dependence has developed to morphine, it is doubtful if any human has the willpower voluntarily to abstain from its use. Withdrawal of the drug results in marked physical distress — lachrimation, rhinorrhea, retching, vomiting, and general bodily discomfort. The subject twitches and thrashes about, a form of behavior which the addict characterizes as "kicking his habit." Within a few days he may lose ten to fifty pounds. After about two weeks his appetite improves, and he begins to gain weight rapidly, generally gaining far beyond his weight during his addiction period. The craving for morphine tends to remain, however, and patients have been known to relapse immediately upon release from custody even where such custody extended over a number of years.

Attempts have been made to separate the euphoric, analgetic, and physical dependence effects of morphine and other drugs. The ideal drug from the medical standpoint would be one which has the analgesic power of morphine without its euphoric and physical dependence actions. A symposium was conducted on this subject in 1943 under the chairmanship of Dr. Fred W. Oberst, with Dr. J. D. Reichard, Dr. Linden E. Lee Jr., Dr. Byran B. Clark and Dr. C. K. Himmelsbach as participants.²¹ Attempts to isolate these effects have been disappointing as far as the opiates are concerned, but some separation has been achieved with non-opiates, particularly with such analgesic-antipyretic drugs as acetanilid and acetophenetidin. There are many problems in this area which are open to the experimental psychologist.

The mechanism of tolerance is not well understood. Although it is true that repeated doses of morphine will enable a subject to take large amounts of the drug without serious physical effects, nevertheless, from a psychological point of view, tolerance does not develop to the same extent as far as sensory-motor and emotional reactions are concerned. Experiments by the writer showed that morphine reduces autonomic responses to emotionally disturbing word stimuli. In a study of a complete cycle of morphine addiction, it was found that the electrodermal response to word stimuli depressed during several months of addition, there being no sign of recovery up to the time of withdrawal. There was immediate recovery following withdrawal.

Many studies have been made on the personality of the drug addict, most of which are difficult to evaluate with any degree of certainty. It is generally assumed that there must be something wrong with individuals who cannot control their actions with reference to drugs. Most addicts are classified as psychopathic, but the term "psychopathy" is frequently a waste-basket classification which contains the "queer" people who cannot be classified properly under orthodox sections. There is no clear cut

evidence to show that the morphine addict is fundamentally different from the general population. As far as general intelligence is concerned, the addict appears to be equal or slightly above the average of the general population². Studies of body build reveal that the addict is inclined toward the pyknic rather than the asthenic end of Kretschmer's classification¹⁶. There are more pyknoid and pyknic types of addicts than there are asthenics. It is quite possible that more refined studies would show fundamental differences between addicts and non addicts, but this only future research can determine.

VI. Barbiturates and Bromides

Since the introduction of Barbital (trade name of Veronal) in 1903 by Fischer and Von Mering, a large variety of barbiturates have been synthesized and produced under different trade names. Barbital and Phenobarbital (Luminal) are the most widely used in this group. Phenobarbital is best known in connection with the treatment of epilepsy.

Most of the barbiturates have the same general type of depressant action on the central nervous system, the main difference being in speed and duration of action. The most common use of the barbiturates is to produce sleep, although drugs in this series may be used for mild sedation, to inhibit convulsions, and even to produce complete anesthesia. Phenobarbital has a selective action on the motor cortex when given in sedative doses, a type of action which is not shared by other barbiturates. Barbiturates do not depress the pain sense and therefore are not considered analgesic. The analgetic effect is produced by loss of consciousness.

Barbiturate addiction occurs, but it is not as common as addiction to morphine and alcohol. The term, "Addiction," is used here in the loose sense, since the habitual use of the barbiturates, although producing a "psychological craving," does

not produce the strong physical dependence which is characteristic of the opiates. Only partial tolerance develops to these drugs.

The potassium salt of bromine was first used as a substitute for the iodides to reduce glandular swelling. The trials were unsuccessful, but the sedative action of bromide was recognized. In 1853 it was used by Laycock as a cure for epilepsy. At that time many believed that epilepsy was caused by masturbation, and since the bromides were found to have a strong anaphrodisiac function, it was natural to try this drug on epileptics. The drug has been somewhat successful, but phenobarbital and more recently Dilantin have proved much more successful.

The bromides tend to produce a mental calm, a decrease in alertness, sluggishness, and finally sleep. Dworkin, Bourne, and Roginski, 1936⁷, reported that sodium bromide improved or cured experimental neuroses in dogs. In this respect it was superior to Alcohol, Avertin, and the barbiturates. Berger (1934) reported that electroencephalograms showed a damping of the alpha waves, thus indicating cortical depression.

Large doses of bromide (10 to 15 grams) may bring on nausea, confusion of speech, and depression. Continued use of the drug leads to mental deterioration, apathy, and loss of sensitivity to touch and pain. The subject may become restless, disoriented, and he may develop hallucinations and show paranoid trends. The bromide user has a fetid breath and frequently develops a rash on the face called "bromoderma."

VII. Cannabis (Marijuana, Hashish, Bhang)

The flowering tops of the plant, Cannabis Sativa, have been used in all parts of the world for psychic "stimulation." This drug is not a typical depressant, but has both stimulating and depressing actions. The plant is commonly known as "hemp" and is used commercially to produce rope and twine. The com-

mercial use of the plant is under strict government control, but it grows wild in almost all parts of the world. The medicinal value of this drug is questionable, since it does not have any specific therapeutic use and there are wide variations in reaction to the drug.

The most common method employed for the administration in the United States is by means of cigarettes called "reefers." Distribution of such cigarettes is illegal and violators are subject to penal incarceration.

One cigarette is sufficient to produce the desired effect if used with the proper technique. The smoke is inhaled and the breath is held as long as possible. Three such inhalations are generally sufficient to produce the desired effect. After approximately 15 minutes, the effect comes on in the form of a flushed feeling and lightheadedness. The room may take on a rosy glow and the subject may feel that he is losing touch with reality. The effect comes in waves, each wave lasting for approximately three minutes. In between the waves the subject is apparently quite clear and normal. The initiated can generally tell when a companion is "going up," apparently by his changed expression and by his facial flushing.

The social setting doubtlessly accounts for many of the variations in behaviour which result from marijuana administration. One of the most common effects is uncontrollable laughter. It has been reported that such laughter is not necessarily a sign of enjoyment, but rather it is a forced response. It might be likened to the laughter of the child in church, where the more the child's mother insists that he be quiet the more helpless he becomes in overcoming his tendency to laugh. In some subjects extreme anxiety and apprehension is produced. The subject may feel that he is going to die and will accept no consolation. Sometimes a subject will become extremely agitated. He may develop ideas of persecution along with hallucinations, all of which

may be recalled as a nightmare when the subject returns to normal.

It has been commonly reported that musicians use marijuana because of its unusual effect on the sense of rhythm. Seconds may appear as long as minutes and in this state the musician is able to make runs and musical variations which would be almost impossible under normal conditions. Further research is needed to verify or deny this reported effect.

The claim that the drug may drive the user to commit serious crimes, particularly of a sexual nature, has never been substantiated. Such stories were of great help to certain governmental agencies, however, since it enabled them to increase the size of their department and therefore the budget. Addiction to marijuana does not develop in the sense of developing tolerance and strong physical dependence. In many instances, however, use of marijuana leads to the use of more seriously addicting drugs.

VIII. Central Nervous System Stimulants

A. Strychnine

Strychnine increases the reflex excitability of the spinal cord and the medullary centers. With heavy doses the muscles become taut, especially in the neck and jaws, with slight twitching in various muscles. Stimulation will throw the subject into violent convulsions involving all of the voluntary muscles of the body. The body becomes rigid and arched backward so that the subject may rest on only his heels and the back of his head. The tenseness lasts for approximately a minute, after which the subject becomes severely depressed and anxious. In all of this time he does not lose consciousness and he suffers severe pain.

The results of strychnine on mental efficiency are difficult to evaluate, since conflicting reports have been given. Poffenberger²² reports no significant results of strychnine on motor

speed and coordination when the drug was administered in doses of 1/30th to 1/20th grain. On the other hand, McDougal and Smith^{18 19} using doses of 1/15th to 3/15ths grains, report increased efficiency in both coordination and in memory. This drug also increases the acuity of taste, touch, smell, and vision. There is some question as to whether the term "stimulation" is correct in connection with the action of strychnine, since the drug appears to sensitize nerve centers rather than directly stimulate them.

B. The Xanthine Compounds

From a number of plants in all parts of the world natives have prepared beverages which are similar in chemical constitution, pharmacological and psychological action. Generally classified "The Xanthines," these drugs are caffeine, theophylline, and theobromine. Compounds derived from these drugs are coffee, tea, cocoa, cola products, and many other lesser known drugs. These drugs stimulate the cortex, medulla, and spinal cord. The medulla and spinal cord are affected only by large doses.

Horst and his co-workers^{10 11}, have shown that sensory acuity increased and motor activity is facilitated. Reaction time is shortened and speed of typing is increased along with a decrease in errors. Tasks requiring delicate motor coordination, however, are adversely affected.

The unusual aspect of caffeine stimulation is that generally the subjects do not recognize the effect. They do not get the "psychic thrill" which is generally reported for cocaine and other drugs.

C. Cocaine

Cocaine is classified pharmacologically as a local anesthetic, but it is of interest to psychology because of its action as a cortical stimulant and because of its sympathicomimetic effects.

Cocaine is an alkaloid obtained from the leaves of the coca tree which is indigenous to Peru and Bolivia, and which has been introduced into India, Ceylon, and Java. In small doses, cocaine is highly effective in reducing fatigue and stimulating cerebration. Natives of Peru and Bolivia are capable of carrying heavy packs for many hours or days under the cocaine effect obtained from the leaves of the coca tree. Laboratory studies making use of the ergograph have furnished further proof that cocaine reduces fatigue and increases work performance¹⁷.

In many individuals cocaine produces an exciting euphoria and the desire for repetition of this affect may lead to "addiction." The cocaine addict is not addicted in the true meaning of this term, since he does not develop strong physical dependence. He does not crave continuance of the drug as does the morphine addict. The usual method of administration as far as the addict is concerned is by sniffing the drug up into the nasal passages. Because of the vaso-constricting action of cocaine, the addict frequently develops nasal abscesses.

Cocaine also has a strong sympathicomimetic action. This is illustrated by reports of cocaine addicts who state that they get the "bull horrors" when they take a large dose. Under such circumstances the addict is overwhelmed by fear and anxiety. He believes he sees detectives and policemen filtering in through the cracks of the doors and windows. On more than one occasion addicts have jumped out of windows to escape. Heavy doses of cocaine may lead to paranoid conditions and the addict may become dangerously violent.

Benzedrine

Benzedrine is a sympathicomimetic drug which is related to epinephrine and ephedrine in its sympathicomimetic type of action. Benzedrine differs from ephedrine in that it produces much greater cortical stimulation, having a longer action than

epinephrine. After oral administration of ten to thirty milligrams, feelings of fatigue are dissipated and the subject experiences a feeling of increased efficiency and alertness. There are wide variations in the effects of this drug. Some subjects experience strong elation, whereas many others simply report elimination of the negative feelings of fatigue and lethargy. Large doses produce irritability and sleeplessness.

Sargant and Blackburn²⁵ reported that mental performance is increased, but the studies of Barmack¹ tend to show that positive increases in mental ability are more fancied than real. Because of its stimulating action, Benzedrine has been used with moderate success in the treatment of narcolepsy and depression. The use of Benzedrine has been increasing, both as a means of relieving fatigue and as a means of producing euphoria and elation. Many cases have been reported of addiction to the drug, although the type of addiction cannot be considered as equivalent to the strength of addiction produced by the opiates.

Drugs Affecting the Automatic Nervous System

Theories of emotion, such as those of James-Lange and Cannon, have focused attention upon the subcortical centers and the autonomic nervous system in explaining the phenomena of emotional reactivity. In spite of this, however, psychologists have not been productive in studies of the effects of drugs on the autonomic. Most of our knowledge concerning the effects of adrenergic and cholinergic drugs must come from pharmacology and physiology. The major interests of the physiologist, however, have been concerned with the cardio-vascular, respiratory, and gastro-intestinal effects of these autonomic drugs.

For an adequate understanding of the actions of adrenergic and cholinergic drugs, a comprehensive understanding of the neurology and physiology of the autonomic nervous system is necessary, as well as a clear conception of the chemical media-

tion of nerve impulses. In the book, "The Pharmacological Basis of Therapeutics," Goodman and Gilman give a concise description of the experimental findings regarding the chemical mediation of nerve impulses and its relation to drugs affecting the autonomic nervous system. There are drugs which act directly on the effector cells, such as Acetylcholine and Epinephrine; there are drugs which inhibit the action of Cholinesterase (which destroys Acetylcholine), such as Physostigmine and the Belladonna alkaloids, such as Atropine and Scopolamine. There are also drugs which inhibit the action of epinephrine, such as ergotamine, and drugs which inhibit autonomic ganglia, such as Nicotine. Many of these drugs offer promise as a means of studying the relationship of autonomic functioning to emotion and mood.

A wide field for psychological research remains in studies on the behavioral effects of drugs of endocrine origin, such as thyroid, pituitary, and the sex hormones. A discussion of these drugs is beyond the objectives and scope of this chapter, particularly since most of the work has been done by physiologists and pharmacologists. On the same grounds, discussion of vitamins must be left to the future.

Conclusion

The modern trend in science is in the direction of collaborative studies by various specialists in order to achieve integration of findings. The techniques of the psychologists are invaluable in studies on the behavioral effects of drugs, but such studies must be integrated with physiological, pharmacological, and neurological findings and viewpoints.

During the war, considerable interest was manifested in the discovery or development of drugs which could be used to eliminate fatigue. It was reported to the author that at one time during World War II as many pilots were lost on landings after

missions as during actual combat. We know that drugs can eliminate feelings of fatigue, increase efficiency, eliminate depression, and elevate mood. These are beneficial and desirable effects, either in war or peace, but unfortunately many of these drugs have unfavorable side actions which rule against their use. Society does not condone thrill seeking through the medium of the tablet or hypodermic needle. Other forms of thrill seeking, as furnished by amusement parks, movies, and athletic contests, are generally not castigated. Amateur pilots and motorcyclists, revivalists, hunters, fishermen, and music lovers all illustrate the common urge for thrills or for escape. The control of the medium by which thrills may be procured is a social and political problem, but the motivation which gives rise to this behavior is a field for psychological research. It may be predicted, that the most significant contributions in this field will be made by those psychologists who work in collaboration with other scientists, and who have more than a passing acquaintance with physiology, neurology, and pharmacology.

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PSYCHOSOMATIC
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By
GREGORY BLECHER, M.D.
New York, N. Y.

VARIOUS KINDS
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Chapter XX

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By GREGORY ZILBOORG, M.D., Psychiatrist

New York, N. Y.

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GREGORY ALBORG, M.D., Psychiatrist

New York, N. Y.

Chapter XX

PSYCHOSOMATIC MEDICINE

By GREGORY ZILBOORG, M.D., Psychiatrist
New York, N. Y.

I. The "Psyche" and the "Soma" Approach

Psychosomatic medicine has come to be considered both in and outside the medical profession as a new and well-established medical specialty.

The psychiatrist is rather hard put to give a clear definition of what psychosomatic medicine really is, and the general medical man does not find it easier to give a satisfactory definition of this supposedly new field. Two rather general but important principles are involved in the job of formulating a definition of psychosomatic medicine. One almost imperceptibly has led people to say that psychosomatic medicine deals with the psychological aspects of somatic pathological conditions; the other—that it deals with the somatic aspects of psychopathological conditions. One, therefore, would insist that the psychiatrist "take over" general medicine or at least general physiology; the other would insist that the internist and surgeon become clinical psychopathologists.

Whether these varying principles were stated openly or not, the actual development of psychosomatic medicine proceeded along one of the two above-mentioned direction lines. Thus the group of the Chicago Psychoanalytic Institute, one of the most actively engaged in this country in the study of psychosomatic

problems, could serve as a good example of the psychopathologist trying to "conquer" the field of physiology. Alexander, French, Theresa Benedek, Saul, and others proceeded to check the psychological and psychopathological reactions of individuals suffering from asthma, gastric ulcers, menstrual disturbances, etc. On the other hand a number of good internists, like Edward Weiss and many others, either are preoccupied with checking up physical complaints against various psychological factors, or occupy a sort of intermediate position usually known as that of interrelating the psychological and physiological factors. The extremes, of course, seem not very convincing; the intermediate position appears less extreme but hardly more convincing, unless one feels that the entities denoted by the terms "psyche" and "soma" are more or less clear in the mind of the investigating clinician.

A. Traditional Emphasis on Bodily Factors

Whatever the claims—extreme or moderate—for the establishment of this separate branch of medicine, the why's and the wherefore's of such claims do not become clarified by their mere assertion. And yet without a clear understanding of the reasons which led to the establishment of psychosomatic medicine, it is impossible to understand what psychosomatic medicine really is, or should be, or might be.

It is necessary to bear in mind that the psychopathologist even today is always hampered by widespread and centuries old prejudices which throughout the history of civilization have clustered around everything that has to do with human psychology. These prejudices, while never fully conscious, have always found open and conscious expression in our social standards, in our philosophies, our current "public opinion," and our judicial systems. This was true of the so-called Middle Ages and of the days when human beings were burnt at the stake for

their own salvation as well as for "the protection of society." This is true today in a number of superannuated forms of establishing the guilt of a given criminal, and of the punishments meted out to many criminals. There was a time when these perennial human prejudices were smuggled in as it were into the conscious expression of social and individual and religious opposition, which was represented by current theology and semi-theological law. Today the prejudices involved in the consideration of human psychology are perhaps officially less severe. They are less open, to be sure; but their unconscious strength is still very potent and they still assert themselves in a "contraband way" in modern science, in biology, in medicine, in religious attitudes, and in current public opinion. There have always been those who insist on the primacy of mind over matter, and those who proclaim the primacy of matter over mind. To understand this agelong discord in psychology and medicine, it is not enough to put a hyphen between the words "psyche" and "soma." That which is divided in principle cannot become united by a mere artifice in spelling.

The historical perspective of the problem is enlightening, and the general evolution of its expression very telling. From this standpoint we must first appreciate how very deeply ingrained in us is the dichotomy "mind" and "body," and how difficult and at times impossible it is for us to imagine that anything abnormal or even extraordinary in our thoughts or feelings is not due to a bodily disease. Hippocratic medicine over twenty-five centuries ago urged that even the state of being in love be considered a physical disease; Hippocrates pointed out that when one is in love, one's face is flushed and one's pulse is abnormally accelerated, that is to say, there exist obvious signs of circulatory disturbances, as we would put it today. For many centuries to come this conception of love as a disease persevered in Greek, Roman, and Arabian medicine—as if the mere presence of phy-

sical signs of an emotional state sufficed to make the diagnosis of a physical (organic) disease. How persistent this traditional idea was may be judged from the fact that Boissier de Sauvages, the great clinician of the early eighteenth century, chose this very subject for his thesis for the doctorate of medicine in the University of Toulouse. He raised the question of whether love (which he took for granted was a disease) could be cured with remedies extracted from certain plants. For this his valiant medical efforts he was even given the nickname, the Doctor of Love.¹ The stressing of the role of bodily factors in human emotions is a deeply seated tradition, a part of our psychology, or rather of our psychological bias, which has been dying hard for many centuries, if it has been dying at all. This bias has become almost a convention, which we neither question nor dare to violate.

Let us take as an example the "self-understood," postulative saying that a healthy mind is found in a healthy body. We accept this dictum with utmost simplicity and plain faith. In this our unquestioning acceptance we have reversed the customary order of this universal phrase and people generally insist that we must have a healthy body in order to have (as a condition of having) a healthy mind—that presumably there is no healthy mind without a healthy body. Our position on this subject is not only unquestioning, but we seem to lend to the belief the appearance of historical ratification by repeating the postulate in traditional Latin: *mens sana in corpore sano*. The verb *est* is legitimately omitted, but is always assumed to be assertively present.

Yet a slight effort to investigate the origin and meaning of this universal truth, universally unquestioned, reveals a curious and rather eloquent set of facts.

It turns out that the statement *mens sana in corpore sano* originally was not intended to be a positive statement of belief;

it was not even a hypothesis, popular or individual, nor was it of medical origin. This expression, which seems to have caught the popular and medical imagination or prejudice many centuries ago, is a verse taken out of context from Juvenal's Satire Number Ten, written over eighteen hundred years ago. The pertinent part of the text in the original reads:

"Nil ergo optabunt homines? Si consilium vis,
 Permittes ipsis expendere numinibus, quid
 Conveniat nobis, rebusque sit utile nostris:
 Nam pro jucundis aptissima quaeque dabunt dii.
 Carrior est illis homo quam sibi. Nos animorum
 Impulsu, et caeca magnaue cupidine ducti,
 Conjugium petimus, partumque uxoris; at illis
 Notum, qui pueri, qualisque futura sit uxor.
 Ut tamen et poscas aliquid, voveasque sacellis
 Exta et candiduli divina tomacula porci,
*Orandum est, ut sit mens sana in corpore sano.**
 Fortem posce animum, mortis terrore carentem,
 Qui spatium vitae extremum inter munera ponat
 Naturae, qui ferre queat quoscumque labores,
 Nesciat irasci, cupiat nihil, et potiores
 Herculis aerumnas credat saevosque labores
 et Venere, et coenis, et pluma Sardanapali.
 Monstro quod ipse tibi possis dare. Semita certe
 Tranquillae per virtutem patet unica vitae.
 Nullum numen habes, si sit prudentia: nos te,
 Nos facimus, Fortuna, deam, coeloque locamus."

And here is the same text in the rather accurate even if a little labored poetical rendition of William Gifford.

"Say then, shall man, deprived all power of choice
 Ne'er raise to Heaven the supplicating voice?
 Not so; but to the gods his fortunes trust:
 Their thoughts are wise, their dispensations just.
 What best may profit or delight they know,
 And real good for fancied bliss bestow:

With eyes of pity they our frailties scan;
 More dear to them, than to himself, is man.
 By blind desire, by headlong passion driven,
 For wife and heirs we daily weary Heaven;
 Yet still 'tis Heaven's prerogative to know,
 If heirs, or wife, will bring us weal or woe.
 But (for 'tis good or humble hope to prove),
 That thou may'st, still, ask something, from above;
 Thy pious offerings to the temple bear,
 And while the altars blaze, be this thy prayer.
 O thou, who know'st the wants of human kind,
Vouchsafe me health of body, health of mind;^{*}
 A soul prepared to meet the frowns of fate,
 And look undaunted on a future state;
 That reckons death a blessing, yet can bear
 Existence nobly, with its weight of care;
 That anger and desire alike restrains,
 And counts Alcides' toils, and cruel pains,
 Superior far to banquets, wanton nights,
 And all the Assyrian monarch's soft delights!
 Here bound, at length, thy wishes. I but teach,
 What blessings man, by his own powers, may reach.
 The path to peace is virtue. We should see,
 If wise, O Fortune, nought divine in thee:
 But we have deified a name alone,
 And fix'd in Heaven thy visionary throne!"²

Please note the *orandum est, ut sit mens sana in corpore sano*, which literally means, "a prayer should be said that a healthy mind be given us in a healthy body"—which in our contemporary idiom could be put as follows: "Let us pray the gods bestow (on our children) a healthy mind and a healthy body." William Gifford was therefore quite right both as to the letter and the spirit of the verse when he translated it, "vouchsafe me health of body, health of mind"—a prayerful wish implying no "psychosomatic" connotations or "psychophysiological parallel-

^{*} Italics mine.

ism." But to the greatest majority of people the obvious meaning of Juvenal's line still remains lost and our prejudice against a psychopathology independent of organic pathology still clings to the old dictum as if it were an age-long and age-tested medical postulate.

We may consider it as an established historical fact that the struggle between the pure psychopathologist and the pure somatologist (organicist, we would say today) is repeatedly reflected in the development of psychological medicine, and that overtly or covertly, this struggle is always active because, whether we admit it or not, we won't give up the artificial division of man into two parts: mind and body. We may note also that "body" always meant body-anatomy, or physiology, or both, but "mind" meant different things at different times. In the beginning it meant soul; it has also meant at times intelligence; in recent years it has come to mean that combination of emotions, instinctual impulses, and the various modes of our social adaptation and habits which Freud called the psychic apparatus—which in turn has nothing to do with the soul as the theologian understands it, or with intelligence as the logician sees it. It is to be expected, therefore, that as the general meaning of the term "mind" changed, the medico-psychological orientation changed accordingly. At the time when mind meant "soul" and intelligence appeared unimpairable by anything but organic disease, any psychological sickness appeared to be nothing but a manifestation of sin. Those were the days of witch-hunting and of the reign of the burning fagots, as a sixteenth century physician called it.

II. The Unitary Individual

Neither the philosopher nor the medical man found it easy to develop our contemporary concept of the unitary individual. Man for many centuries remained a house divided in itself—

into mind and body. About one hundred and twenty years ago this divided and divisive point of view brought about a rather severe scientific struggle. Anatomy and physiology had made considerable strides throughout the sixteenth, seventeenth and eighteenth centuries and medical interest in human psychology had developed to an enormous extent. Men like Haslam in England, Bayle in France, Heinroth or Reil in Germany had built the foundation of modern neuro-psychiatry. The perennial puzzle and struggle of mind and body had somehow to be solved and resolved.

As was pointed out elsewhere,^{3 4} two extremist camps drew their lines for the battle. There were the psychologists who believed that the psyche itself could become abnormal, ill, and thus produce a mental disease; and there were the organicists whose reasoning was as simple and as disarming as it was almost preposterous. Illness, they claimed, human frailty, is a manifestation of imperfection. Since the soul is by definition perfect, they went on, how then could the soul become ill, i.e., imperfect? Their conclusion was both inevitable and clear: only the body can become ill and through its illness interfere with the functions of the perfect soul.

Narrow as this point of view might appear to some of us today, it was not wholly sterile, because it opened an era of intensive studies in biology, physiology, and anatomy, particularly the brain; it also served to underline the great need to bring together, if not to unify, the problems which man as an individual faced when he was troubled in mind or body. Medicine began to seek for a clue which would explain the relationships between mind and body in health and disease, and the 'thirties of the past century reflected that search. In America as well as in Europe the medicopsychological issues of the mind-and-body problems were pondered and hotly discussed. The term "mental dietetics" came into use during those decades; Amariah

Brigham, one of the original founders of the American Psychiatric Association, and the founder of *The American Journal of Insanity*,* reflected and represented the spirit of the times when he wrote, "On the Influence of Mental Cultivation and Mental Excitement upon Health," (Boston 1838).

A. Jacobi and Nasse, First Psychosomaticists

In that same year the German physicians Jacobi and Nasse, imbued with the spirit of the time, began the publication of the first journal on psychosomatic medicine. Their term, in literal translation from the German, was "psychophysical medicine." The publication of this short-lived journal may be considered from two points of view. On the one hand it was an attempt (almost the first real one) to introduce medical psychology into the field of organic medicine—a scientific medical psychology rather than the purely humanitarian, philanthropic one which had prevailed theretofore. On the other hand Jacobi and Nasse's publication can be viewed as an attempt to describe clinically the interaction between mind and body, or rather affects (passions) and body. It is important, of course, not to read into this endeavor more than was actually in it: the first two German psychosomaticists of 1838 did not as yet have at their disposal a working concept of the unitary individual, of the human personality, and therefore they were unable to go beyond a certain psychophysical "common sense" parallelism.

The course of the century which followed Jacobi and Nasse, was marked by an increasing emphasis on a mechanistic, physiological orientation, which fascinated a number of outstanding scholars in the field of biology and medicine. It is the influence of Darwin, of course, that is reflected in the work of such outstanding medical pathologists as Virchow, Aschoff, Claude Bernard, and Ramon y Capal. Yet it was the very enthusiasm for

* Now *The American Journal of Psychiatry*.

the mechanistic, materialistic philosophy of medicine which gradually produced considerable dissatisfaction among the proponents of the anatomico-pathological and purely physiological philosophy of medicine, and of course of medical psychology as well.

B. Adolph Meyer's Psycho-biological Point of View

Some psychopathologists did sense that fragmenting a human person into so many organs and blood-cells and reflexes breaks down the personality into its elementary components, and by the same token sacrifices the very person in the process. These psychopathologists began to seek for a concept of the unity of the individual, of "the personality as a whole." As a matter of fact, even biology, general medicine, and surgery began to be aware of the fragmenting influence of the prevailing anatomico-physiological values, and the concept of "the organism as a whole" began to assert itself with greater frequency and authority. It is not accidental, therefore, that it was Adolf Meyer, a man thoroughly grounded in pathological anatomy and physiology, who was more than anyone else in America responsible for the introduction into American psychopathology of the concept of "the personality as a whole," of the *psycho-biological* point of view. Meyer, almost at the same time as Freud, i.e., toward the close of the nineteenth century, seems to have felt the need of a true synthesis between biology and psychology, and most of his years of active scientific life he devoted to the search for such a synthesis—which search is also reflected in what has become known as psychosomatic medicine.

C. Freud and Psychosomatic Medicine

During those closing years of the nineteenth century Freud worked as a neuropathologist and in his earlier articles, before he coined the term "psychoanalysis," he used the expression "we neuropathologists" to designate specialists interested in psycho-

pathology. Freud remained throughout his life a Darwinian biologist and a confirmed believer that it is chemistry and physiology which will ultimately yield the essential clues to the solution of psychopathological problems. In other words, Freud's turning to purely psychological research was not an introduction of "panpsychology" into abnormal psychology, but rather an earnest attempt to apply the biological methods in their strictest but not narrow sense to the problems of human emotions and behavior. In this sense Freud too, if not particularly, could be considered one of the chief originators of psychosomatic medicine. One of the earliest problems which Freud chose to consider he viewed in the light of what might be called today psychosomatic medicine; it was the problem of conversion symptoms, which he considered a phenomenon of changing innervations. Freud was so fully aware of the "wholeness" of the human personality that in reporting one of his cases he described the appearances of certain digestive symptoms in the course of psychoanalytic treatment by saying: "I had the satisfaction of seeing . . . his bowel 'join in the conversation.'"⁵ Comparatively early Freud raised the problem of the choice of neurosis, and in his communication to the International Congress of Psychoanalysis in Munich in 1913, he asked ". . . why any particular person is bound to succumb to one particular neurosis, and no other." . . . "Our predispositions to various neuroses are thus seen to be inhibitions in development. The analogy with the facts of the general pathology of other diseases strengthens this view. The question of what factors can induce such disturbances in development does not lie within the boundaries of psychoanalytic investigations; we must leave it to biological research."⁶

D. The Two Extreme Camps Revived

However, despite avowedly common points of departure and common basic medico-psychological premises, the major medical

disciplines or specialties seemed more to cherish the awareness of the things that separated them than to concentrate their attention on the things that united them. Medicine became preoccupied with almost purely chemical and physiological problems, and man seems to have been reduced in the research laboratories to a mere test tube or rabbit. Meanwhile psychiatry, under the increasing pressure of facts uncovered by psychoanalysis, became broken up into at least three camps: one purely neurophysiological—which is the first extreme; another purely psychological—(mostly under the influence of psychoanalysis)—which is the second extreme. The third camp was more or less undefined and has remained predominantly eclectic, with the usual propensity of the eclectic to borrow from everyone and contribute to no one branch of human psychology. The extreme camps remained fairly clearly delineated and most self-assertive. By the time one entered the fourth decade of the present century the old struggle of a century before seemed to have become revived. The organicist drew his line and “dug in” to hold fast against the “panpsychologist” with his “unscientific metaphysics,” while the psychopathologists (now almost predominantly psychoanalytical) either began to give in and let their system become fragmented into various “schools” of thought, or stood their ground bearing the brunt of critical blows for having allegedly forgotten or rejected the cornerstones of medicine—anatomy, physiology, and biology. It was almost exactly one hundred years after the previously mentioned publications of Amariah Brigham in America and of Jacobi and Nasse in Germany that Flanders Dunbar’s *Emotions and Bodily Changes* appeared⁷—which “is the standard work of reference for anyone interested in this field.”⁸

It would be wrong, of course, to assume that between the two extremes of thought there is nothing but wasteland, and that the “psychosomatic compromise” of 1938 was nothing but a twentieth century, spontaneous re-appearance of the psychosomatic

compromise of 1838. The history of ideas, even less than the history of politics, knows of no sudden transition or of any sort of historical spontaneous generation. Inconspicuously ideas keep on "working, fermenting." The struggle goes on uninterruptedly; no peaks, no "pitched battles," and no victories would occur without this constant, invisible, but ever-potent work and struggle. There is never any real peace and quiet on the clinical medical front. The underlying conflict has never subsided;—more than that, it has actually always remained in the forefront of medical thought. Why the battle should become at times more violent, the contentions more bitter, and the assertions more harsh is difficult to say. Perhaps a special re-study of the historical perspective would yield the answer. But even a cursory glance at the century just marked off would reveal how psychology, i.e. psychopathology, gradually "intruded" into the field of medicine, and how biology continued its rather unsuccessful attempt to create or establish a human psychopathology without psychology.

E. The Soma and Psyche Conflict—Sub-Acute in America

In Europe this struggle of medical ideas and clinical methods of approach was no different from that in America, but because of certain historical coincidences, and perhaps also because of America's greater pragmatic proclivities, it was America who led the way in opening some of the strongest medical bastions to psychopathology and thus led the way toward the establishment of psychosomatic medicine. In other words, from the 'thirties of the past century onward the conflict between the somatologist and the psychologist remained sub-acute in America, never really becoming quiescent. Amariah Brigham was typical of the times, and of America, and of the ultimate solution of the problem. Some of his remarks on dyspepsia sound modern even today, a hundred years after they were made and almost

exactly a century before Franz Alexander started approaching the problem of the psychopathological aspects of the peptic ulcer. Said Brigham: "But I apprehend that in a majority of cases dyspepsia is primarily a disease of the brain and nervous system"⁹ and further "Dyspepsia belongs to the brain-working, brain-worrying and nerve tone exhausting element, to those who bother their brains and eat little or not over much, rather than to those who gormandize; to those who burn the midnight oil in study, do not sleep from fret and worry and carking care, rather than to the *bon vivant* high liver and he who tarries long at the wine. It belongs to the man of affairs and women of care, to the infelicitous and the disappointed in hope and ambition."¹⁰

This incrustation of a sort of embryonal, semi-physiological psychology into medicine bore little fruit; the remainder of the nineteenth century was anything but psychological. Weir Mitchell's "Fat and Blood"—which appeared in 1877—was by far more representative of the prevailing mood in medical quarters than A. J. Ingersoll's "In Health," which appeared in the same year and in which we find the almost Freudian statement that "Hysteria is frequently caused by voluntary suppression of sexual life."¹¹

III. Twentieth Century Psychiatry

In contrast to the latter part of the nineteenth century, the very beginning of the twentieth was marked by the definite rise in influence of psychopathology. Freud's views on conversion symptoms or the purely psychological origin of certain physical symptoms which were but demonstrations of how our organs "joined in conversation" with our unconscious reactions—all essentially or even exclusively of emotional origin—these views and the whole psychoanalytic theory of psychogenesis produced a rather telling revolution in medical thought. The "infiltration" of psychoanalysis into medicine and surgery was not difficult

to observe, but it was slow and laborious and mostly unwelcome to the traditional physiologist, whose authority remained pre-eminently unchallenged not only in his laboratory but in the whole field of medicine. However, the ever-increasing influence of psychopathology—which influence was generated by Freudian psychoanalysis even in quarters which would not willingly or even consciously acknowledge the true nature of this influence—together with the ever-growing interest in psychological problems turned the attention of many a physiologist toward psychological problems.

A. Crile's Limited View of Emotions

George W. Crile, an eminent surgeon and physiologist, published in 1915 a series of papers under the general title "The Origin and Nature of Emotion." In this book Crile made a number of interesting and correct observations and drew a number of curious and incorrect conclusions, in the tradition of the times and his specialty. He insisted, for instance, on "the pathologic identity of surgical and emotional shock,"¹² he measured correctly the hydrogen-ion concentration of the blood in the emotions of fear and anger. But emotions to Crile were only the gross conscious affects which were known in the ancient world, in the Middle Ages, and during the Renaissance as passions; their number was more or less determined, and their nature was considered sort of independent, like special faculties of the endowment man brings with himself into this world, alike in substance in all men. Rage, anger, fear were just rage, anger and fear; the physiologist did not ask himself: "What was the given person in rage about?" "At whom was he angry?" "Was he afraid of someone or of something?" In other words, the quality of the emotion seemed to be all that mattered; its direction, its psychological origin, its meaning to the person who happened to experience it—all these were non-existing questions; no one

thought about these things, no one cared whether the various emotions examined had any unconscious roots.

All these questions were raised by Freud; the curiosity as to the origin of our given, individual, personal emotions and drives was the mainspring for psychoanalytic research. But all these aspects of human psychology still seemed foreign to traditional physiological science, and Crile was, therefore, able to say with that sense of complete satisfaction which a scholar feels when he thinks he has found a clue to a mystery of nature: "Emotions cause increased output of glycogen. Glycogen is a step towards diabetes and, therefore, this disease too is prone to appear in persons who are under emotional strain and who are especially emotional in character."¹³ Crile concludes that it is the emotional component that makes Jews predisposed to diabetes. Here the word "emotion" gradually acquired the meaning of excitability or demonstrativeness—a meaning devoid of psychological significance or of scientific weight. At the same time it does appear rather paradoxical that the organicist Crile, who would not consider an emotion as a psychological phenomenon unless he was able to combine it with some physiological equivalent like glycogen, without his being aware of the scope of his admission, does conclude that diabetes might develop on the basis of emotional factors. It is true that one would not impute to Crile the recognition of the psychogenic origin of some organic, or functional, physiological complaints, but there is no doubt that Crile, unbeknown to himself, was skirting on the borderlines of the psychogenetic theories which at that time were being expounded by A. A. Brill, Smith Ely Jelliffe, and William A. White as the first representatives of Freudian psychoanalysis in America.

B. Cannon's Contribution

Contemporaneously with this more or less speculative excursion of Crile we find the fundamental work of Cannon being

done at Harvard.¹⁴ Cannon's experiments are of importance not only from the standpoint of his finding some specific physiological accompaniments of certain readily observable affects, but from the standpoint of the gradual drifting of physiology and medicine toward some, be it ever so partial, recognition of the importance of psychopathology in medicine. In other words, the very first two decades of our century, despite the initial intense opposition to psychoanalysis, showed a countercurrent against this opposition moving toward a synthesis which was to begin some twenty years later.

C. Draper's Idea of "Panels of Personality"

There were many signs foreshadowing the attempt at this forthcoming medico-psychological synthesis. The work of Ernst Kretschmer in Germany and particularly that of George Draper in America, who urged that the patient be looked upon not from the narrow perspective of his symptoms and complaints only, but from the standpoint of the various "panels of personality"—anatomical, physiological, psychological and immunological. This was another and very telling step in the direction of looking upon the patient, any patient, "organic" or "mental," as a totality, as a personality one and indivisible, whose emotional life is as important in illness as is his hydrogen-ion concentration in the blood.

D. The Decisive Emphasis of White

It is thus and against this background that medicine in America came to the crossroads at which it encountered an ancient opponent—psychopathology—and came to make it a friendly helper. By the time this almost friendly encounter took place, some time in the 'thirties, medicine was not entirely aware of what was in store or even what was needed. It is a matter of historical fact, and a very eloquent one, that this time, as through-

out medical history, it was psychopathology, clinical psychiatry, that made the first step, forced the decisive turn, and carried the torch as it were. This is exemplified by the efforts of William A. White, who for almost four decades—mostly in collaboration with Smith Ely Jelliffe but not infrequently alone—carried the message of modern psychiatry into the midst of medical strongholds. In his "The Meaning of Disease"¹⁵ and "Twentieth Century Psychiatry"¹⁶ White literally pounded into the heads of his readers the simple but to the traditionalist rather offensive truth that "psychiatry is the one medical specialty which in its broadest conception can be seen to be the central point of all the other medical specialties; for it is only from the standpoint of the psychiatrist, or, perhaps better, from the psychological level, that the significance of disease of the various parts of the body can be understood."¹⁷

These were not the mere words of an old enthusiast of clinical psychiatry, but rather a terse and reserved statement dictated by experience and medical wisdom. For it became at the time a matter of common knowledge in the medical profession that a great many patients suffering from seemingly or actually physical, organic conditions presented actual or presumptive evidence that there was in the given condition "a psychological component." It became the current although statistically at that time not yet verifiable opinion among the physicians themselves that seventy to seventy-five per cent of patients coming to the offices of general medical men were mostly or solely neurotic, despite their numerous physical complaints. However, the knowledge of psychopathology on the part of the average medical man is very meager indeed, and the willingness of the average patient with headaches, stomach aches, or chronic constipation to consult a psychiatrist is minimal if not zero, even if the personal physician made bold and suggested such a consultation. Only very

severe mental aberrations seem to convince the people concerned that "there must be something mental about it." This has always been a real psychological difficulty; the age-long prejudice against recognizing that "anything is wrong with my mind" awakened to do its work of destructive reluctance in both patient and doctor. Cognizance of the extreme intensity of this difficulty must be taken if we are to appreciate the immense job that psychopathology had to perform, and the true value of the contribution modern psychopathology made to medicine in producing that which we have come to designate as psychosomatic medicine.

IV. Psychoanalysis and Psychosomatic Medicine

The history and the scope of this contribution is in reality the history and the scope of Freudian psychoanalysis. For of all psychoanalytic "schools," Freud alone remained on the firm basis of medico-psychological and psycho-biological research. It is, therefore, both understandable and scientifically inevitable that the pioneering work and the major contributions to psychosomatic medicine were made either by practicing psychoanalysts or by physicians who had undergone a psychoanalysis before they became productive in the field of psychosomatic work. Here are the names of but a few of the earliest and most active workers in the field. H. Flanders Dunbar—the true pioneer and still the major reference source. Felix Deutsch, Stanley Cobb, Franz Alexander, George Daniels, O. Spurgeon English, Edward Weiss, Leon Saul, Carl Binger, and the co-workers of the *Journal of Psychosomatic Medicine*, whose first editor was Dunbar and who was succeeded by Carl Binger. The *Journal* was founded in 1939. The latest contributions to the literature on the subject are by Flanders Dunbar¹⁸ and Felix Deutsch¹⁹—both practicing psychoanalysts. It is rather revealing in this respect to notice two features concerning the most complete text on psy-

chosomatic medicine.²⁰ 1) the full title of the book reads, "Psychosomatic Medicine—The Clinical Application of Psychopathology to General Medical Problems"; and 2) The list of selected references (fifteen in all, of which one is the *Journal of Psychosomatic Medicine*) is headed by: *The Basic Writings of Freud*, collected and edited by A. A. Brill, and *The Medical Value of Psychoanalysis* by Franz Alexander.

In other words, psychosomatic medicine is both from the formal historical point of view and from the standpoint of content in some way connected with psychoanalysis. In which way? Simple and natural as this question is—it is not easy to answer. It is not easy because once psychosomatic medicine declared itself officially present, the general public, lay and medical, were inclined to claim considerable familiarity with the new arrival. Of course, the claim was made that the body and the mind do work together; this has never been denied by any responsible person. Because this claim is to a great extent justified, it is difficult to observe its major insufficiency. There is no denying that the moment we look at a person and observe, "you look worried," we have made what is called a psychosomatic observation, and we have, extended recognition to psychosomatic medicine: there is something in the body that tells you what there is in the mind, and perhaps *vice versa*.

A. The Major Issue in Psychosomatic Medicine

But this is not the major issue; in psychosomatic medicine the major issue is the recognition of the ever-present unconscious emotional factors which either produce physical symptoms of no organic significance or "cooperate" with an already existing organic pathological condition, worsening it and confusing the purely organic pathological picture. It is the differential diagnosis of every physical symptom²¹ that belongs to the sphere of

the psychosomatic physician, and it is this job that is the chief burden and skill of this physician.

B. The Psychosomatic Physician Emphasizes Total Personality

His skill requires a considerable and intimate familiarity with psychopathology, which means with the psychology of the unconscious, with the psychology of instinctual life and its biopsychological (unconscious) vicissitudes. Furthermore, it requires an unswerving adherence to and familiarity with the total personality, with the personality as a whole which at no time, even "for purposes of argument" can be broken up into independent parts, and which at no time can be considered a kind of machine which produces certain somatic phenomena in response to psychological processes, and psychological ones in response to somatic processes. There was a time when such interacting parallelism was considered to be an incontestable fact, and psychoanalytic psychiatrists even tried to find for it plausible psychoanalytic explanations. Hollós,²² for instance, tried to explain the euphoria which is so frequently found among people suffering from paresis (known in the older literature also as general paralysis) by assuming that the brain being the chief organ of the ego and the brain being especially affected by the syphilitic bacillus in paresis, the human ego reacts in an over-compensatory fashion to the major impairment of its organ. Such an explanation will certainly fail to explain the reactions in brain tumors, in cerebral arteriosclerosis, and other types of illnesses in which the brain is the main victim. This explanation will also fail to shed any light on those states of exaltation, megalomania, and euphoria in which the brain is not affected at all.

C. Why We Act Psychologically is a Question

The conclusion imposes itself that in the application of psy-

chopathology to clinical medicine the physician must reject or go beyond the constant comparison of how we react psychologically to given physical diseases. To be sure, the death anxiety in cases of coronary occlusion, the optimism and the tendency to intense activity in cases of tuberculosis, and the hopeless surrender in cases of cancer are rather typical psychological manifestations: but the real answer to the problem has not yet been found, and one would readily agree with Bunker²³ who quotes Carl Binger and others from a monograph on "Personality in Arterial Hypertension"²⁴ "It is not certain that 'psychic factors' are even 'causative' of 'somatic disturbances.' Even in far simpler experimental situations such as Cannon's early observations on the bodily changes which accompany certain emotional states, it is more useful to think of adrenal secretion and sympathetic discharge as being not in 'causative' relation but as somatic manifestations of a process which psychologically we recognize as rage and fear. The rapid cardiac rate associated with anxiety is *not caused by anxiety* but is the *somatic* expression of the same phenomenon which subjectively is experienced as anxiety. Increased cardiac rate does not *cause* anxiety, nor does anxiety *cause* increased cardiac rate. This is more than argumentative hair-splitting. To make this relation plain seems essential to clear understanding."

V. Psychosomatic Medicine Not a Specialty

The above statement, general as it is, is an excellent expression of a psycho-biological principle which grew out of psycho-analytic psychopathology, and which went beyond the formalistic confines of the James-Lange tradition of physiological psychology. And because through the formation of psychosomatic medicine we set out on the road leading toward a greater and deeper synthesis of the bio-psychological functioning of the human being

as an individual, we are apt to overlook the fact that psychosomatic medicine is strictly speaking not a separate specialty, not a branch of medicine (or of psychology for that matter), but rather a scientific product of a period of transition which is as transitory as the period itself. It is, therefore, doubtful whether it is scientifically or clinically correct to speak of *psychosomatic complaints*, or *psychosomatic symptoms*, as differing from somatic or psychological symptoms. These expressions have already crept into the medical idiom under the guise of a new terminology, whereas in substance these expressions are but the jargon in vogue characteristic of the enthusiasm for or opposition to anything new and striking.

From the standpoint of clinical and curative medicine, he who wishes to practice psychosomatic medicine must be a good physician who is also a good psychopathologist. In other words, psychosomatic medicine is not a new specialty which deals with newly discovered *psychosomatic* phenomena but rather is a deepening and extension of both medicine and psychiatry with increased burdens on both; more psychopathology must be learned by the physician, and more medicine by the psychiatrist.

The words, "psychosomatic medicine," mean, therefore, not a new specialty but a new era in medicine while they denote a transition similar to that which took place around 1838. They do more than that in marking a *new* transition—a transition toward the unification of our divided and fragmented views on man, toward a oneness which biological sciences, medicine, and psychology lacked throughout the nineteenth century.

It is rather impressing and revealing of the essential depth of the human intuition that the philosopher Plato, twenty-five centuries before Darwin and before Freud, was able to urge upon us the very thing which psychosomatic medicine is now called upon to perform. It was H. A. Bunker who called our attention

to that passage in *Charmides* which reads: "So neither ought you attempt to cure the body without the soul; and this is the reason why the cure of many diseases is unknown to the physicians of Hellas, because they are ignorant of the whole, which ought to be studied also . . . For this is the great error of our day in the treatment of the human body, that physicians separate the soul from the body."²⁵

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Chapter XXI

SUGGESTIONS AND HYPNOTISM

By DONALD A. ROTHSCILD, Ph.D., Psychologist
Eastern Illinois State College, Charleston, Illinois

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Eastern Illinois State College, Chicago, Illinois

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1. Introduction

A. Hypnotism and Surgery

The Congress of the United States, in the year 1853, considered the problem of appropriating \$10,000 as a reward to the American dentist by the name of Morton who in 1845 had demonstrated the anesthetic effects of ether and had, thereby, opened the possibilities of forever freeing surgical patients from pain. It goes without saying that Morton made a great contribution. However, James Esdaile, a British surgeon, while not claiming the reward, sent a letter of protest at the time, explaining that painless surgery had been performed in England since 1842. He stated that doctors had performed surgery, even major amputations, without the patients showing pain or other apparent ill effects of the operations. Furthermore, he claimed that it was a well known fact that painless surgery had been performed in his and other hospitals years before ether had even been heard of. These feats were made possible through the use of that unique and interesting phenomenon called hypnosis. Possibly hypnosis reached its climax of importance at that time. For a while it showed promise of rising above the vale of superstition and magic. If other more reliable and surer scientific methods of anesthesia had not come into practice, perhaps the history

of hypnosis might have been different. The trail at any rate is an interesting and varied one.

B. The Work of Mesmer

The beginning of the study of hypnosis finds us at the baquet of Franz Anton Mesmer (1734-1815). Zweig¹ tells us, "Franz Anton Mesmer was a learned gentleman, and a wealthy man. He had a lovely home, a charming wife, and all those characteristics which make for many friends who would assemble in his home for talk. By chance one of his friends was an astronomer who had been asked to provide a simple magnet to treat his wife's ailment. He told Mesmer and Mesmer became interested in the treatment. When Mesmer observed the cure, he resolved to try the method himself. The result was that Mesmer had success himself in this new technique.

There are differences of opinion among writers regarding the subsequent practice of Mesmer. On one hand, we have those who believe that Mesmer was a charlatan; that he saw the possibilities of using the magnet as a tool, and by some means beyond his understanding, it formed a device whereby he could work a cure. He cashed in, therefore, on his strange process, and fell into disrepute. On the other hand, we have those writers who regard Mesmer as a man of science, and while he might have made mistakes in his reasoning, he was nevertheless always interested, honest, and sincere. As proof of this view, they refer to his attempts to find a cause for the power he had discovered. While today we look with humor on his explanations, we must nevertheless not forget that Mesmer lived over a century ago.

The reasoning of Mesmer was as follows. Some years previous he had become interested in the influence that the planets might exercise on the body. He conceived some kind of universal fluid, an invisible gas which he named "gravitas Universalis." By the chance experience above described, the magnet had been called

to his attention as possessing some kind of healing power. While this occurred years later, it, nevertheless, called to mind his reasoning of the previous time. Wasn't a magnet metal, and therefore, as it possessed magnetic powers, weren't those powers or forces simply the forces coming from a part of a planet? He had reasoned and found the relationship of the connecting forces between the universe and mankind. The power of the magnet was thought to influence the transforming or transmitting of the universal fluid. The individual who was ill needed more fluid. The magnet was the dynamic means whereby the force could be transmitted, and as it was transmitted, the patient was cured. Those that were not cured simply didn't get enough fluid. The reasoning was simple, and we might suppose for that day fairly sound. At least Mesmer thought so. The result was that he had considerable success and rose in popularity. His clientele became so large that he found it necessary to treat them in large numbers. He developed as a result what we now know as the famous "baquet." The baquet which Mesmer constructed and used was apparently a large oak chest. This chest was filled with liquid and fitted around the rim were jointed iron rods which were used as a means of transmitting the magnetic fluid to the subjects. As Boring² suggests, "The circle appears to be the ancestry of the circle of spiritualistic sitters of the present day." That Mesmer was a showman and was aware of the helpful background of soft light and music cannot be denied. Zweig³ described the scene realistically:

He therefore surrounded himself with an atmosphere of magic. Like all mental healers, he enhanced his position of authority by an assumption of mystery. The room where his patients were treated impressed them as soon as they passed through the threshold by the peculiarity of its setting with the result that they became slightly troubled and excited. The windows were screened by curtains so that no more than a dim twilight should pervade the place; thick carpets, and hangings on the

walls deadened every sound; mirrors were so placed as to reflect a golden light; strange astronomical signs were introduced to attract the attention and at the same time to leave the mind unsatisfied. The indefinable always enhances expectation, mystery gives rise to tensions; silence and secrecy stimulate the emotions. Hence in Mesmer's room every sense—those of sight, of hearing, of touch—was titillated in the most delicate way in order to produce a combined effect of soothing and stimulation. Like a great pool, the healing tub, the famous baquet, stood in the middle of the room. As in church, silence prevailed, and the sick would gather breathlessly expectant around the magnetic altar. No movement was allowed, no word might be uttered lest by the slightest sound the tension should be destroyed. At a sign, the "magnetic chain" (taken over at a later date by the spiritualists) would be formed. Each participant would touch the fingertips of his neighbor so that the stream of magnetism might pass from body to body and increase as it glowed through the meditative circle. From another room would come strains of a pianoforte, or the dulcet tones of a choir—For an hour the body would be charged with magnetic energy; or as we should prefer to phrase it today, by monotony and expectation the organism would be ripe for suggestive therapy. At length, Mesmer himself would enter upon the scene—he would draw near to the patients gathered round the tub; at his proximity a gentle fit of trembling would spread through the assembly as if a zephyr had come to ruffle the placidity of a pool.

As one examines the foregoing scene, he cannot help but be amused. But while we look today upon it with ridicule, we must realize that he was getting results. In 1776, a report of the Ausburg academy stated that he had discovered one of nature's systems. The paradox remains, however, that in spite of his apparent financial and medical success, he was not accepted by his profession. Furthermore, Mesmer somewhere along the line came to the realization that the magnet was not in itself the basic reason

behind the cure. He reasoned, rather, that the personality that used the magnet was in some way responsible. The result was that after the year 1776 magnetism became "animal magnetism." The iron of the magnet and the resulting forces from it had been exchanged for the animal energy emanating from the finger tips of the operator. Mesmer stated, "of all the bodies in nature, none is so potent in its influence upon man as is the body itself." Zweig¹ tells us that after 1776 "Mesmer's practice consisted largely of suggestive and hypnotic treatment." The point we should consider, however, is that Mesmer had not as yet developed an understanding of the importance of the subjective aspect of the problem; that in the main, the functioning of magnetism was but the *functioning of the mind of the patient himself* as brought about through the objective presentation of stimuli to the strength that these suggestions were considered and acted upon by the patient. The later years of Mesmer's professional life were ones of dispute between him and the physicians, scientific organizations, and the state. Owing to a dispute over his right to give public lectures, the French government appointed a commission in 1784 to investigate the truth of his claims. An interesting circumstance was that Benjamin Franklin who was in France at that time served as one of the members on the committee. The result of the committee's report was that Mesmer was denounced as an imposter and forbidden to practice his art in France. The result was that he finally settled in a small community a short distance outside of Zurich, Switzerland, where he practiced until his death in 1815. With Mesmer's death, interest subsided in the phenomenon which bore his name. This was especially so in France. In England, however, two men were stressing the practices of Mesmer. In fact, the experiences of these two men as they practiced under the British crown paralleled to a degree the experience of Mesmer.

C. The Defense of Mesmerism by Elliotson

John Elliotson (1791-1860) was appointed assistant physician to the St. Thomas hospital in 1791, and by 1823 had progressed to senior physician. In time he earned the privilege of giving lectures to the students of the college. Elliotson was decidedly successful. He was an inspiration to his younger colleagues and his teaching was selected as ideal. He had an understanding of the past, but his eyes were cast to the future. As Bramwell³ says, "He had a look of skepticism to that which was old, and a look of confidence to that which was new." He was one of the first physicians in England to use a stethoscope, and for such modern ideas, he was greeted with ridicule and scorn. No wonder, then, that when the opportunity arose for him to observe the effects of Mesmerism he approached the problem with an open mind. Elliotson was given this opportunity in 1837 when Sennevoy de Dupatel visited England and demonstrated Mesmerism. The result of Elliotson's observation was that he appreciated the possibilities of the novel technique and immediately became interested in the possibility of its development as a new therapeutic device. He was met with the typical criticisms characteristic of his contemporaries. Some of his colleagues even boasted of their refusal to attend his lectures. Elliotson might have been relegated to obscurity had it not been for his strong personality and influence among his students. While his colleagues scoffed, others attended his lectures in such large numbers that he was forced to move to larger quarters. The dean of the college urged him to desist, stating that it was considered that the interests of the school should have been considered rather than the interests of science and humanity. The fear of loss in public favor apparently was of more importance to the school than the possible benefits which might have been derived by use of this new tool in the modern treatment of disease. The argument continued,

until finally in 1838 enough pressure was brought to bear with the result that the council of the University College formally passed resolutions prohibiting the practice of mesmerism or any other forms of animal magnetism. The force of such an action was particularly bitter to Elliotson. In spite of the fact that he held the position of senior physician, the majority of the physicians on the council had actually refused to witness his experiments, to say nothing of discussing them with him. Rather, they passed the censoring action just described. He bided his time, however, with the result that his chance came when it became his turn to give the Harveian oration. Elliotson made mesmerism the subject of his address in spite of the anticipated criticisms and pressure from various quarters for him to act to the contrary. He admonished his colleagues to study mesmerism calmly and critically and to recognize that although most great discoveries had been opposed violently by the profession they had nevertheless withstood the test of time. Even though he was ignored, we must conclude that he nevertheless pressed on. There were times, even, when the scientific journals would not accept his contributions on mesmerism. Furthermore, references to discussions on animal magnetism and mesmerism were deleted from the proceedings of the learned societies. Elliotson was a fighter. He, therefore, began publication of his own periodical—the ZOIST. The journal was formed for the "Collection and Diffusion of Information Connected with Cerebral Palsy and Mesmerism." Case studies covering all phases of mesmerism were published. These studies, together with the complete publications, were of course subject to criticism. The magazine existed as a quarterly from April, 1843 until December, 1855.

As Elliotson progressed in his study of mesmerism, he became interested not only in the therapeutic values of the subject, but also in the possibilities of its use as an anesthetic agent. The medical profession was naturally interested in painless sur-

gery, but it apparently closed its eyes to the possibilities of this new agency. Possibly if new anesthetic agencies in the form of nitrous oxide, chloroform, and ether had not made their appearance in a relatively short time, attention ultimately might have been directed to the possibilities of animal magnetism. The facts are that phenomenal progress was made in the anesthetic possibilities of mesmerism. The contributions of James Esdaile are outstanding examples in this respect.

D. The Work of James Esdaile

James Esdaile (1808-1859), after preliminary training in Edinburgh, assumed charge of one of the Crown hospitals in Calcutta, India. At first Esdaile was not primarily interested in mesmerism, but one day, having trouble with a native Hindu suffering untold pain, he decided to mesmerize him. He didn't know a great deal, having simply read incidentally some of Elliotson's publications. The interesting result was that the process worked. The rest of the story is obvious. He became interested and tried many more cases, all of which responded with considerable success. The hospital reports found their way to higher sources, with the result that the usual pressure was exerted. The deputy governor of Bengal appointed a committee to investigate. Curiously, however, the pattern differs from that of Mesmer and Elliotson, for the committee gave a favorable report. The result was that a small hospital was placed at Esdaile's disposal. These circumstances made for even greater successes with the result that a further group of medical officers gave a most favorable report at the end of the year. Case studies were printed in the *Zoist*, and other notoriety was given to the work of Esdaile. Possibly because India was such a great distance from the mother country, the unfavorable influences with which Elliotson was forced to associate were not to be immediately felt. In due time, however, for some reason the hospital was ordered closed and

Esdaile was "called to assume other duties." The importance of Esdaile's work had developed to such proportions, however, that the results did not pass unobserved. He had performed close to three hundred major operations before he left India, all while the patients were under mesmeric anesthesia. In short, the results which Esdaile experienced were phenomenal. In answer to his critics, Esdaile made the following important observations:

- (1) In his sixteen years of experience previous to 1845 he had operated on only eleven patients, but since he had begun his mesmeric technique, he had been called on to perform more operations in one month than took place in all the other native hospitals for a year.
- (2) During the operations patients remained perfectly quiet and showed no evidence of pain, while previous patients had shown acute pain when operated on in the waking state.
- (3) There was no pain following operations when mesmeric technique was used.

On the basis of these observations, Esdaile made the comment, "If they were not all imposters, they were certainly all hysterical." In spite of the steady growth of mesmerism, and in spite of the preponderance of objective cases as reported by Esdaile and others, mesmerism still was not recognized by the medical profession.

E. James Braid Discovered Hypnotism

It remained for Dr. James Braid, another Englishman and doctor of some recognition to break down the barrier and bring mesmerism within the realm of respectability.

The pattern begins in about the same way. J. De Lafontaine was scheduled to give a series of public exhibitions in Manchester on mesmerism. This occurred just a few years after Elliot-

son had resigned from the University College, and thus considerable public interest was professed in the exhibitions. The Manchester Guardian was particularly outspoken, and while the meetings started small, they soon grew through the popular appeal that they made to the lay person. James Braid chanced to attend one of the meetings and in following the particular pattern of the medical profession was outspoken and facetious in his actions. The interest of the audience, however, seemed to be on the side of mesmerism in spite of objections to the contrary. We must recognize that in spite of the objections raised by learned men, the bare fact remains that many of the mesmerized subjects did enter into typical cataleptic states, and in these states showed obvious, though mute, evidence of the power of the mesmerist. It was easy to shout fraud, but, nevertheless, the results spoke for themselves. Today no one questions the fact that Elliotson attained important results, or that Esdaile relieved pain. The difficulty centered not so much in the fact that these men and others were wrong in their practice, but rather in the fact that these men had not even grasped the true significance of what they were working with. They were producing a perfectly normal psychological phenomenon, but were completely lost when they reasoned the cause of the phenomenon. It remained for Braid to read new meanings into the thinking of the time.

As we stated, Braid criticized Lafontaine's exhibitions loudly, but he fortunately didn't stop there. He was curious to the extent that he went back to try and figure out what was going on. He made observations on this second trip which he missed previously. For one thing, he discovered that the subject was actually not able to open his eyes. It is even said that Braid forced a pin under a fingernail of one of the subjects without eliciting any apparent reaction. On another subject, he lifted the eyelids and noted the un-natural contraction of the pupils. All these novel observations started Braid to thinking. He must be given

full credit for his next move. In spite of his having made a number of overt criticisms and having ridiculed previous experiments, he realized that there definitely was a phenomenon which was real and different, and had the courage to realize it as such and proceed in the true scientific way to ask himself the Reason. He continued further to observe carefully and critically the exhibitions, and then he turned to his own laboratory and experimented further. It was much to his surprise that he found that he too could produce similar conditions in his colleagues, and even members of his own family. The problem remained for him to think through a reason for this new phenomenon. He was not so naive as to believe that the phenomena were caused by any particular power of magnetism nor any power that he held as a magnetizer. Rather, he reasoned that the experiences actually evolved through the subjects themselves, and were the result of the subject's own particular behavior. In short, Braid realized that mesmerism was nothing more than a device, and not a too clever one at that, to produce sleep. The result of Braid's thinking was that he found himself in a rather peculiar position. On the one hand, he was looked upon as a critic of mesmerism, and therefore gained the confidence of his colleagues. On the other hand, he was free to hold public demonstrations because everyone thought he was demonstrating the fallacies of mesmerism. He attracted large audiences with whom he not only criticized the ideas upon which mesmerism was based, but also suggested his own views. These views can with few changes even today be accepted as sound. He published his basic work,⁴ *Neurypnology, or The Rationale of Nervous Sleep, Considered in Relation with Animal Magnetism*. Herein he proposed the term neuro-hypnology to designate his doctrine of nervous sleep. The term was shortened to neurypnology and finally changed to hypnology from which the words hypnotic, hypnotism, etc. were developed. In conclusion we can refer to Braid's contribution brief-

ly by saying that where his predecessors, and even some of his contemporaries were mesmerists, which signified magnetizers, magicians, and the like, he was a hypnotist, which signified a psychological phenomenon. Hypnotism had advanced significantly with this change in view.

F. The French School

It is generally considered that there are three stages in the history of hypnotism. The first period is exemplified by the contributions of Mesmer. We had in that period the pseudo-magic patterns in which Mesmer, without being aware of with what he was dealing, really attained considerable success. Though Mesmer's success was doubtful, there is not much question related to how he stood with his professional colleagues. They held him in thorough disrepute with the result that when he died, little was done until the second period where we find Braid attempting to devise techniques of some therapeutic value, especially as an anesthetic. Though Braid approached the problem with insight similar to our understanding of the problem today, after a short while interest in the subject dropped. The reason possibly is found by noting the tremendous strides that the medical profession made in the use of anesthetics. The need for hypnotism as patterned by Esdaile, Elliotson, and Braid simply ceased to exist. The third period introduces us to later work of the French school, finally culminating in the philosophies of auto-suggestion as promoted by Coué. Hypnotism as a therapeutic agent of any consequence, however, has not made a place for itself in modern scientific procedures. As we have suggested, other more reliable and significant techniques have been developed which well overshadow the minor contributions previously related to hypnotism.

The development of the French school is interesting. Liebault was a French physician who settled in Nancy in 1864. He practiced hypnotism on some of his poorer patients who attended

his clinic. Liebault had been practicing for a number of years, when, apparently as a mere routine, he treated and cured a patient of a Professor Bernheim, a professor of the Nancy Medical school. The result was that Bernheim appreciated the possibilities of this new practice and expressed himself accordingly. Charcot, on the other hand, became interested while at Paris. He was familiar with the experiences of Mesmer, and was wary of the various claims made by practitioners. He was therefore very careful not to make the same mistakes. The paradox was that Charcot in his caution overlooked the most important matter. He failed to recognize the importance of the subjective element in the phenomenon. Rather, making the mistake of assuming that animal magnetism was the basic cause of the experience. Charcot⁵ even introduced a new term, "transference."

"When the ulnar attitude has been produced in the right hand, and a magnet brought close to the subject's forearm, when he is asleep, and even when he is awake, both his hands become agitated with slight jerking movements; then the contraction of the right hand ceases and is *transferred* to the left hand without losing any of its characteristics or its precise location"—

Bernheim, however, exposed the basic errors in the procedures as reported by Charcot and his followers with the result that the teaching of Liebault gained in importance. The main significance of the Nancy school centers around Emile Coue and his auto-suggestion.

Emile Coué became well acquainted with Liebault. In fact, he practiced hypnosis and suggestion according to Liebault's technique. However, as Coué thought and studied, his view finally developed into a purely subjective approach. Coué believed that the problem primarily consisted in developing within the individual himself the proper mental organization which would make the mental phenomenon possible. The result was that he founded what came to be called the neo Nance school. Coué⁶ said:

"Every time you have a pain—go quietly to your room, sit down and shut your eyes, pass your hand lightly across your head if it is mental distress—or upon that part that hurts—and repeat the words—It is going, it is going—etc."

Boring² summarizes briefly the significance of the Nancy school:

Hypnosis was accepted as a fact, and the dispute was concerned with its nature. The theory of the Nancy school, which differed but little from Braid's later views, held that the phenomena were to be considered in terms of suggestion, and were thus entirely normal phenomena. The school of the Saltpetriere (Charcot) believed that the phenomena were essentially hysterical in nature and thus symptoms of abnormality. The verdict of time had favored the Nancy school, but the controversy was fortunate for it dismissed forever the suspicion that hypnosis was not a proper subject for scientific inquiry.

The approach of Coué represents a far cry from the first practices of Mesmer nearly a century before. Hypnotism had gained a position of respectability.

II. The Phenomenon of Hypnosis

As the phenomenon of hypnosis is discussed together with all of its resultant characteristics, it should be considered from the outset that it is basically a psychological experience. It must, therefore, be explained in terms of the basic principles of psychology with which we are familiar. In short, hypnosis is a mental state, and resultant behavior patterns are caused by an organization of mental experiences. There are two sources from which we may gain insight into the problem. The first, and foremost, is the subject; i. e., the hypnotic. The second is the experimenter, called the hypnotizer or operator. The latter, of course, has under his control or direction all of the external objective factors incidental to the experiment. Only when these

two factors are analyzed and brought under scientific scrutiny can we secure a true picture of hypnosis, together with an understanding of its causes and effects.

A. Bramwell's Method of Inducing Hypnosis

There are various methods by which hypnosis may be produced. Bramwell³ describes the method he used on a patient;

I rarely attempt to induce hypnosis the first time I see a patient, but confine myself to making acquaintance, hearing an account of his case, etc. In most cases he has either read misleading sensational articles on hypnosis or his friends have painted the dangers in striking colors. I endeavor to remove erroneous ideas and refuse to attempt to induce hypnosis until the patient is satisfied with the safety and desirability of the experiment. I never tell the patient that I am certain of being able to hypnotize him, but always explain how much *depends upon his own mental condition and power of carrying out my directions.*"

Note how Bramwell is placing the patient completely at ease, and very subtly shifting the responsibility for the success of the experiment from the experimenter to the subject. It is not a question of what "I" am going to do to you, but rather a question of what "you" will do yourself at my suggestion. Continuing with Bramwell's discussion we find:

I then say, "Presently I shall ask you to look at my eyes for a few seconds, when probably your eyelids will become heavy and you will feel compelled to close them. Should this happen, I shall ask you to shut them, and to keep them shut until I tell you to open them. I shall then make certain passes and suggestions, but I do not want you to pay much attention to what I am saying or doing. Above all, you are not to attempt to analyze your own sensations. Your best plan will be to create some monotonous drowsy mental picture, and to fix your attention upon that. You must not expect to go to sleep. A certain number of hypnotized persons pass

into a condition more or less closely resembling sleep; few do at the first setting and you must only expect to feel drowsy and heavy."

After these explanations I darken the room and instruct my spectators to remain quiet. I place my patient in a comfortable chair and request him to look into my eyes, at the same time bringing my face slightly above and about ten inches from his. The patient's eyes sometimes close almost immediately. Should they not do so, I look steadily at him and make suggestions. These are twofold; the patient's attention is directed to the sensations he probably is experiencing and others which I wish him to feel are suggested. Thus; "your eyes are heavy, the lids are beginning to quiver, the eyes are filling with water, you are beginning to feel drowsy, your limbs are becoming heavy, you are finding it more and more difficult to keep your eyes open, etc."

Sometimes this produces the desired result. The eyes close and the first stage of hypnosis is induced. If this does not take place, I direct the patient to close his eyes and make passes over the head and face, either with or without contact, repeating meanwhile appropriate cervical suggestion. This is continued for half an hour. No stereotyped method is employed, however, the process being varied with different patients or with the same patient at different times.

Bramwell closes his description by calling attention again to the fact that it is necessary to develop proper cooperation. The extent of this cooperation measures the degree which will or will not assure success of the experiment with either complete or varying degrees of success:

"To insure success, it is necessary to understand the mental condition of the patient—to gain his intelligent cooperation and to create a clear picture of hypnosis together with an expectation of its appearance."

B. Cataleptic and Hysteria Induced

After the subject has developed a hypnotic condition, or

mental state, he is more or less subject to any reasonable suggestions the experimenter might make. Extreme hallucinations are common and even an extreme muscular rigidity bordering upon catalepsy may be induced. In fact early investigators concluded that the hypnotic trance was actually a pathological condition allied to hysteria, and hence only those persons who were functionally unbalanced could be hypnotised. Such a view has long been discredited, however, and instead we recognize the cataleptic state as a form of rigidity produced through the cooperation of a highly suggestive subject. The example of anesthesia as reported by Esdaile are typical examples of extreme hysterical cataleptic states which were developed in the minds of the subjects. Surely everyone at some time in his life has cut or thought he has cut himself severely. As he looks back on the experience he remembers how he wildly squeezed the wound and for a brief time experienced a mental condition bordering upon hysteria. Pain as a psychological experience did not evolve for some time. Such experiences can similarly be noted in the reports of Mesmer and even in those of other technicians as they are followed down to the present time.

C. Hypermnnesia

Another phenomenon which has been recognized and applied with varying success is hypermnnesia induced through hypnotic suggestion. The condition is brought about by suggesting to the subject while under hypnosis that he recall previous experiences. Generally he appears to be able to perform the feat with considerable ease. Some patients have been able to report past experiences with degrees of clarity which are phenomenal. Experiences are recalled which date many years previous. He recalls as a child the many details involved in his first day of school. The big bow ties and the Little Lord Fauntleroy suit, the arrangement of the school room, all are remembered even

down to the minute details with a clarity that baffles expression. These hypermnesiacal experiences are always interesting, and while they may have some semblance of authenticity, generally when checked objectively they turn out to simulate patterns of fancy rather than patterns of fact. It would seem wise, therefore, to accept only those examples which can be objectively proved as true. When such criteria are used, we may evaluate the results in a proper manner. It is contended that so-called normal, or un-hypnotized persons under experimental conditions can also produce phenomenal memory patterns. Give them the inclination, develop the interest, suggest that they give the matter their primary attention, make a few suggestions as the experiment proceeds, and the experiences reported will compare favorably with those produced under a hypnotic state. In short, it is suggested that hypnotic hypermnnesia implies nothing particularly phenomenal or magical, but rather that we could obtain comparable results in the psychology laboratory under normal scientific experimentation.

D. Hypnotic Sleep

Another characteristic of hypnosis is what has been described as hypnotic sleep. It has been erroneously concluded that the condition was the same as natural sleep. It is assumed that the subject drops into a stage of sleep bordering on unconsciousness, or a state of coma. The observations both present and from our childhood stand before us as vivid examples of this peculiar condition. One of the wierdest examples is one which came to attention a short while ago. In this case, the subject was hypnotized and put to sleep. Then he was placed in a glass-covered coffin and lowered into a grave where he could be observed through a tube placed in such a position that for a nominal sum of twenty-five cents apiece anyone interested could gaze at the person as he lay buried in restful slumber. Two

persons soundly asleep in conveniently displayed beds in the show windows of the town's progressive furniture store might be another instance. These illustrations are examples of hypnotic sleep and should not be compared with natural sleep. It is true that the subjects might have dozed off into a form of natural sleep, but they were performing the typical psychomotor functions which were suggested to them by the experimenter. If such suggestions implied a sleeping state those specific suggestions were carried out and the pattern of sleep was produced. In natural sleep the individual is unconscious. At least we consider that the depth of sleep is closely correlated with the extent of conscious experiences. Learning, hallucinations and perceptual experiences, for example, are not experienced in natural sleep. However, in hypnotic sleep, we may induce these experiences at will and even alter the interpretation of the perceptual cues.

Another characteristic of the hypnotic state is called rapport. It is observed that the subject will follow only the directions of the operator. Although numerous and varied commands given by the operator will be followed by the subject, any other person who attempts to suggest or make certain commands will be ignored. This is called Rapport. Rapport may be transferred from one operator to another. The subject is hypnotized, and then directed to follow the directions of a different operator. The patient will readily follow the suggestion and follow directions as presented, provided he has confidence in the intent of the new person.

Perhaps the most peculiar characteristic of the hypnotic state is post-hypnotic suggestion. This particular phenomenon is the most difficult to account for. The subject is hypnotized and then carries out the various suggestive patterns which are discussed. He is then offered one final suggestion. He is told that upon awakening he will do a certain thing. It may be a rather simple task such as closing a window, or a fairly complex suggestion

such as turning off the radio after a period of ten minutes. The interesting fact is that if the subject is given a reasonable chance to check on the time, or even to approximate it, the suggestion will be completed with fair accuracy. During one experiment it was suggested to the subject that after five minutes had passed he should shut off the phonograph. When the person was awakened, the phonograph was playing. It continued to play, and even ended one side of the record. Shortly after the second side had begun, however, the subject abruptly arose, walked across the room and shut off the machine. When asked why he had done it, he explained that he had noticed a definite change in the pitch of the music, and he had shut off the machine because he thought something might have gone wrong with it. The example illustrates not only the effects of post-hypnotic suggestion, but also the rationalizing one might practice to carry out the suggestion. Incidentally, the record was replayed shortly afterwards and no apparent defect was noted by the subject. Another time a second person was given similar directions, the only difference being that the phonograph was not left running. In this second case the person showed no particular concern either way. It may be concluded that suitable circumstances were not present to facilitate carrying out the suggestion, and it was not completed. Available evidence indicates that subjects are aware of the post-hypnotic phenomenon and will perform within limits of reason. McDougall^{7 8} gave a subject a toy rubber dagger, and directed him to stab a person shortly after. As long as the subject understood fully that the dagger was perfectly harmless, the suggestion was carried out. McDougall concluded that when a person's morals, or when a sense of justice or feelings of a personal nature were involved, not only would the post-hypnotic suggestion be negative, but also negative results would be secured to suggestions made under direct hypnosis. This and other evidence reveals how necessary it is for the subject to have

complete confidence in the operator. Unless this rapport is secured and maintained, hypnotism is not possible.

III. Theories of Hypnotism

The historical development of hypnotism has been outlined and some of the important phenomena involved have been described. The next step is that of discussing some of the theories which have been proposed to explain hypnosis. The views of Mesmer and his followers have been mentioned, where they supposed that some invisible body or animal fluid controlled by the operator caused the subject to come under the magnetic influence of its curative powers. We might consider this era as the era of magic or hocus pocus. We cannot overlook its influence, however, for even today the man on the street looks upon mesmerism in that magic light. We find Braid developing a purely subjective approach to the problem. He believed that the condition was purely a mental condition of the subject, or the result of a mental organization in which the operator, who was but a motivating agent of some sort, held a secondary position to the actual phenomenon itself.

A. Charcot's Theory of Hysteria

Charcot went to even further extremes and conceived of the hypnotized person as developing a certain mental condition comparable to hysteria. He concluded that only those persons which were inclined towards hysterical imbalance could be hypnotized. Charcot was correct in some respects. A hypnotic condition is definitely a state of mental organization, and has been commonly observed as such. The individual can be, among other things, induced to assume a cataleptic condition similar to hysteria. However, it must not be assumed that just because a person can be hypnotized, and while

under that condition carry out the suggestions which call for a cataleptic condition, the person is basically functionally unbalanced. If the criteria for hysteria were measured in terms of these factors we would have many, many hysterics. The opposite, in fact, appears more evident. The prime requisite of a satisfactory patient is that he have the ability, desire, and intelligence to maintain a state of primary attention, and still be subject to suggestibility. Such requirements are not found in the unintelligent or the functionally maladjusted, to say nothing of the hysteric.

B. Theory of Mental Dissociation

Other early investigators attempted to explain hypnosis as a function of mental dissociation. The basis of their reasoning was to compare the way the brain functions in normal as compared to hypnotic sleep. It was reasoned that in normal sleep the neurones in the cerebrum became dissociated with the result that as the dissociation developed, the individual lapsed into unconsciousness. It was considered that a similar condition applied to hypnosis. In hypnosis, however, in place of all the neurones in the brain becoming dissociated, only part of the brain was affected. The remainder of the brain was free and available for the special attention of the operator. Because all but that part of the brain which was under the direction of the operator was quiescent, suggestions were naively accepted. There was no questioning of the ideas developed by the pre-occupied section with the result that the patient accepted suggestions without question. The individual lapsed into unconsciousness in all respects but those related to the hypnotic condition. The fallacy of such a theory lies in the concept of partial dissociation. Experimental evidence has long disproved such a form of mental organization.

C. The Ideation Theory

A more modern view suggests the possibility of including some form or degree of ideation as a means of explaining hypnosis. The thesis is based upon the concept that the mind of the individual in hypnosis is concentrated or directed toward a single idea. As the individual concentrates further on that idea, the effect results in the strengthening of his concentration on the ideas to the exclusion of any other contradicting forces. That is, we assume that the degree of attention or concentration of the individual may be increased from point to point as suggestions are offered by the operator. Now with a normal person, or with a person in normal waking life, every idea that develops is subject to the forces of doubt. Each problem must be weighed and through the process of reasoning, a conclusion is reached which reduces the doubt factor to a minimum. This conclusion may be based upon three factors: an intellectual factor, an emotional factor, or a combination of both. The individual may approach the problem with a cold, unemotional approach, and upon weighing the evidence of factual material as presented, come to a definite conclusion or belief. On the other hand he may be swayed by emotional forces to such an extent that he will disregard all evidence to the contrary and come to his own desired conclusion. Or he may employ the two together. In any case the individual weighs the evidence, removes doubt as far as possible and comes to a satisfactory solution to his problem. In hypnosis the problem is much simpler. Ideas evolve through clever suggestions offered by the operator. These ideas are not given to questioning by the individual but are accepted blindly as fact and immediately turned into individual action with little or no consideration as to the consequences of the act. The individual performs the act in a simple voluntary way, similar to the behavior observed in automatic writing. In short,

everyone is open to suggestion. If you suggest to a person that he become extremely suggestible, and he does that is hypnosis.

The important feature of the view explained above is that there is nothing novel or different in our concept of a hypnotic mind as compared with a normal one. We take a person, and offer suggestions and he accepts those suggestions. The only difference between the hypnotized and a normal person is a *quantitative* difference rather than a qualitative one. No phenomenon is produced here that cannot be produced or demonstrated to a lesser degree under normal waking conditions. Watch the individual antics of the spectator at a football game. No one deliberately tells him to act as he does. He has unconsciously submitted himself to the suggestive forces of the occasion or crowd. He accepts without question the view that he is doing the proper thing, and he does it in a purely uninhibited way. Take the same person into the psychology laboratory and ask him to go through the same antics and he will tell you not to be foolish. On the other hand, suppose we persuade him to place his confidence in the hands of an operator, and suppose further that the operator requests him to give his undivided attention, and then what happens? He is sensitive to suggestions and will carry out those suggestions in the same uninhibited way that he did out on the football stadium. The primary factor responsible for the variations in each of these examples may be measured in terms of the strength or force with which the person subjects his attention to suggestive ideas. If he is convinced it's the proper thing to do, he'll do it. Some one with authority must convince him that he's doing the right thing. Hull⁹ has offered a term to describe the condition. He calls it "prestige suggestion." When the prestige suggestion reaches a certain strength we have a resultant hypnotic condition. Some people are affected quicker and to a higher degree than others. Some are not affected at all. The degree to which the individual desires to cooperate and

submit to suggestion indicates his ability to be hypnotized. Hull⁹ states further that this heightened susceptibility to prestige suggestion is about twice as strong in the average hypnotic case as compared with normal conditions. It seems inadvisable to indicate an exact figure to indicate this strength however. The factor certainly must vary from individual to individual, and we may also observe variations at different times in the same individual. Such factors as intelligence, will to cooperate, confidence in oneself, confidence in the operator, the emotional condition of the patient and a host of other factors all play their part in determining the degree of prestige needed to develop the hypnotic state. The primary factor to consider as we view the causes of hypnosis is for us to realize that the condition is not pathological. The brain does not change, and above all there is nothing of the magic or occult about the phenomenon. We rather have a *quantitative variation* in cortical functioning which represents a purely normal condition, and when viewed in that light, lends itself to the rather simple explanation given above.

IV. Hypnotism and the Future

The psychological phenomenon of hypnosis has had a long and varied career. It has played its part as a charlatan's tool. It was also used by the skilled hands of the early surgeon. Parlor entertainment and the tricks of the magician are all too common. The question remains: what of the future? What are its possibilities as a therapeutic tool and a diagnostic agent? No one doubts but what hypnosis has played and will continue to play a part to some degree in the study of mental ills. It is subject to the limitations imposed upon it by prestige suggestion, and, therefore, is not as reliable as other devices which are at the disposal of modern science. We have hypnotic forming drugs, and many other more reliable and objective techniques. It does not seem feasible to suggest that future uses of hypnosis

will be great. The phenomenon is an interesting one, and should be studied as one of the many psychological experiences with which we are familiar. Husband¹⁰ implies this view clearly when he said, "As a comment on the place of hypnosis in psychology, the writer might observe that of the hundreds of friends in the field of psychology, scarcely half a dozen have ever been hypnotized."

Possibly we should consider its importance in this light.

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Chapter XXII

PSYCHIATRIC TREATMENT

By JOHN M. LYON, M.D., Head, Division of
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**JOHN M. LYON, M.D., Head, Division of
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University of Colorado Medical Center, Denver, Colo.

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By

JOHN W. FLOYD, M.D., Head, Division of
Psychopathic Medicine
University of Colorado Medical Center, Denver, Colo.

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By **JOHN M. LYON, M.D.**, Head, Division of
Psychosomatic Medicine

University of Colorado Medical Center, Denver, Colorado

1. Treatment of Body and Mind According to the Individual

Any discussion of psychiatric treatment, if complete, would include the treatment of all diseases known to man. This is a true statement for good physicians do not treat diseases, they treat people. A physician never treats just a sore; he treats a person that has a sore toe and that sore toe influences that person's total behavior. The ramifications and complexities of a sore toe on a person's personal affairs, his economics, his loves, hates, etc., may be more important than any local pain or disturbed physiology. Furthermore, different diseases produce different personal problems and different personality types react in various fashions to the same disease. The treatment of personality disorders, then, is the sum total of all medical lore; it is the art and science of the practice of medicine. Psychiatric treatment is based upon this premise. Treatment must be given to the whole individual and any attempt to separate psyche and soma is not only unwarranted but illogical and actually impossible.

Granted then that a physician must treat people and not diseases, there still exists a great difference in the technique

required to treat a sore toe and the technique required to treat the emotional instability that led the owner of the sore toe to go on an alcoholic binge and get his toe mashed in a drunken brawl. Special knowledge is required if the person with the injured toe goes on to develop delirium tremens or gets a depression because he can't work and support his family. This ability to treat obvious personality deviations is psychiatric treatment at the specialty level, but must always be based on sound medical training, for again the psyche cannot be separated from the soma. Too many personality disorders stem from physical disease directly or are aggravated by co-existing physical defects for anyone to attempt to treat the psyche alone. Psychiatry without the body ceases to be a medical science and becomes an ism, cult, or religion that fails to hold to the announced goal of treatment of the whole individual.

Many psychiatric disorders such as the senile psychoses, the mental defectives, the brain injuries, etc., are treatable only insofar as good nursing and custodial care are concerned. These people need constant medical attention for intercurrent infections, bed sores, dietary deficiencies, etc., and psychotherapy as such has a small role to play. People who have major psychoses and whose contact with reality is seriously disturbed are again hospital cases. A discussion of their treatment would include the shock therapies, special surgical procedures, the use of drugs, ward management, etc., and does not admit much of a role for direct psychotherapy. The topic of psychiatric treatment at the specialty level, then, becomes too involved and further limitation is indicated for the present purpose.

The above explanation is a necessary preface for this chapter. The idea that mental disease is an entity and the same wherever you find it is much too prevalent. Actually, there are many types of personality disorders and each type can vary in type and manifestations from one person to the next. The type of

psychiatric treatment utilized depends entirely upon the type of illness encountered, its duration, its particular manifestations and many other factors. Any attempt to take up each known psychiatric disorder and discuss its treatment is not proposed but instead it is proposed to discuss a few of the broad principles of psychotherapy. The discussion is undertaken with the full recognition that it applies only to a limited number of psychiatric disorders and that if a division seems to be made between psyche and soma, it is only an arbitrary division for purposes of discussion and can never be carried into actual treatment.

II. The Challenge of the Therapist

The case of Mrs. A., a thirty-five year old, white, married woman: Mrs. A. was referred by her family physician for psychiatric aid after an exhaustive physical examination had failed to disclose any reason for her numerous symptoms. She complained bitterly of a pounding heart, breathlessness, insomnia, restlessness, epigastric pain, tremor, dizziness and headaches. She stated that she was unable to work because of extreme fatigue but felt no better when she went to bed. She was fearful of being alone and when her husband had to leave her, she felt such fear that she was in a panic. She used any device she could think of to keep someone in the house with her, preferably her husband. If such was impossible she would often go with her husband or go to a neighbor's. Her fear was, she said, that her heart might stop or her breathing shut off and she would die if there was no one around to help her.

These symptoms made their appearance about a year after Mrs. A. was married and had gradually got worse. She had had several diagnoses but treatment had not altered the steady progression of the symptoms. Three years prior to her referral for psychiatric aid and two years after the onset of the symptoms, she had been advised to have a baby. This advice was carried

out, but Mrs. A. was sicker after the baby than before. It was in desperation that she consented to see a psychiatrist and openly made known her resentment and hostility. She doggedly insisted upon a physical diagnosis and apparently had yielded to demands that she consult a psychiatrist only in the hope that the psychiatrist might agree with her. She was obviously terrified of the first visit and talked with pronounced pressure about her physical symptoms as though to preclude any other line of conversation. She elaborated again and again that her fear of being alone was entirely understandable and should not be mistaken for some quirk in her mental make-up. She spontaneously insisted that she had no worries and that nothing was preying on her mind.

Mrs. A. was a woman of high intelligence and above average education. She showed excellent taste in clothes and her speech and manner indicated a good cultural background. Prior to her marriage she had held a responsible office position in which she had demonstrated organizational and administrative ability. She was known by her friends as an independent, brilliant, successful person who was impatient with delay or demonstrations of affection. She was also known to have a lively temper and a sharp tongue, but on the other hand, she could be great fun and had a ready sense of humor. Throughout her illness she had always been able to present a good front to her friends and relatives. She would entertain and go to a party but she said every minute of such time was sheer agony and that she was being torn to pieces inside. Her husband and close relatives had refused to take her condition seriously after doctors had said nothing was wrong. She was admonished to "get ahold" of herself. Mrs. A. was no hysteric seeking sympathy and attention so she had kept her complaints to herself and was a thoroughly miserable person. She hated her illness with a passion and was ashamed of it since it seemed to be some kind of personal weak-

ness. She was too intelligent to go about denouncing doctors for not being able to find out what was wrong and her common sense told her that the doctors were capable men. She was puzzled, embittered, lonely and wracked by the symptoms of anxiety, but to look at her one saw only a pretty, well-dressed, vivacious lady.

The history of Mrs. A. is not unusual and will serve as a starting point for a discussion of psychotherapy. What should a therapist do with such a case? What does a therapist say? What tools are there to work with? What is the diagnosis and the prognosis? What treatment goals can be envisioned? What advice, if any, should be offered? What can be said that can convince Mrs. A. that she has no physical disease? These and many other questions come to mind and they are difficult to answer. They loom even more difficult when it is remembered that qualified, capable physicians had tried for several years to help Mrs. A. without success. She had been reassured repeatedly and had been given advice by sincere advisors. She had been berated and laughed at. These methods would seem useless and hardly worth trial.

III. Steps in Therapy

A. The Ability to Listen

The first and foremost quality of a good therapist is his ability to listen to his patient. It almost goes without saying that no physician can learn anything as long as he is talking. A physician must have the patience to wait out even the most long-winded tale for every patient behaves in his own particular manner and the therapist must attempt to understand this behavior. Whatever a patient does he does for a reason. Mrs. A. talked rapidly and well for a full interview but the reason for such pressure was to forestall any questioning and prevent any attempt to place her difficulty on an emotional basis. The thera-

pist realizing what was taking place kept quiet and thereby avoided what would have been an argumentative situation. Mrs. A. was ready to beat down any implication that her trouble was of a psychiatric nature and would have avoided treatment by forming a personal dislike for the therapist. By not challenging her symptoms, by not threatening her with a psychiatric diagnosis and by not offering platitudinous advice, the therapist appeared to Mrs. A. as a friendly, cooperative person who was at least willing to listen to her side of the story.

The fact that a therapist is willing to listen means a lot to a patient. How frequently patients are heard to say about their doctors, "I just can't talk to him!" When such a situation is analyzed, it is usually found that the therapist can't resist breaking into the patient's story to present his own views or to openly question the validity of some statement. The old method of taking a history by the question and answer method leaves little or no initiative with the patient. Such a routine may completely prevent the patient from telling what he actually has on his mind. The therapist who remains quiet and keeps his ears open will learn a lot. Every psychiatrist has had the experience of having patients pour out a highly intimate story during the first interview; the psychiatrist may then have asked, "Why didn't you tell your doctor about this?" The patient's answer, indicating the average physician's unwillingness to listen, is quite illuminating.

Mrs. A. spontaneously stated that she felt better at the end of the first session. She said she thought that the psychiatrist was going to ask her a lot of questions about her sex life and probe into her past history. She felt just a bit sheepish because she had been so direct and had been so obviously on the defensive. She sensed that she had given the psychiatrist no chance to say anything and because of her insistence that "all was well" with her personal life, she may have felt that she had protested

too strongly. She revealed some of these feelings by trying to explain her protests as the first hour closed.

B. The Physical Examination

A physical examination is excellent psychotherapy if it is conducted and interpreted in the proper fashion. It has worth even with those patients whose difficulty is purely on an emotional basis and, of course, is imperative whenever physical factors are being incriminated. A physician is in no position to have an opinion about a patient's physical status until he has made his own personal examination. Mrs. A. felt sure that there must be something wrong with her heart or it would not "pound so hard and fast." The therapist could not logically make any comment about her heart until he had at least listened to it. The examination of Mrs. A. produced no abnormal physical findings except a spastic colon which was, of course, in keeping with her anxiety. During the examination Mrs. A. spontaneously stated that she suffered some menstrual cramping but had not submitted to a pelvic examination since her routine check-up following the delivery of her baby. It was apparent that a pelvic examination should be done. The therapist did not question why she had refused previous examinations or why she wanted one now. The following interview Mrs. A. wanted to know particularly of the status of her pelvic organs and then admitted that she felt something might be wrong with her because intercourse was so painful. The fact that the psychiatrist was interested in her physical condition was also evidence that there was not going to be a blind insistence that she accept a functional explanation for her illness.

Every person has some small physical deviation from the normal. These deviations are often asymptomatic but sometimes they contribute to the over-all symptomatology. The identification of these physical defects and their correction are indicated.

Such things as carious teeth, refractive errors, acne, painful cal-luses, infected tonsils, etc., can be treated as part of the total treatment without incriminating them as the cause of the psychic unrest. The therapist finds that attention to these physical details is appreciated by the patient for several reasons. The improvement of a troublesome acne may go far in helping a patient with his self-assurance, or treatment of some other minor physical detail may give the patient a face saving reason for medical attention that he can tell to his friends.

Symptomatic relief of aches and pains is good psychotherapy; analgesics for headaches, drugs for anorexia, anti-spasmodics for indigestion, etc., provide relief for the patient and help to form a better patient-physician relationship. Mrs. A. had two complaints that could be relieved by symptomatic treatment. She was given a mild sedative to help her secure more rest and she was given a bulk producing laxative to relieve the discomfort caused by her spastic colon. She felt much better being able to leave the office armed with two prescriptions. The therapist was playing her game the way she wanted it played. She did not find herself in the position of having to go back to her husband and relatives and admit that they were right about her trouble being all in her head. What took place between Mrs. A. and her doctor was her own business and any conclusions reached in the doctor's office were safe and could be handled as she saw fit.

C. The Psychotherapeutic Interview

A psychotherapeutic interview consists of a patient and his doctor sitting face to face and discussing whatever problems the patient presents for consideration. Rarely should sessions last for more than fifty minutes and they are scheduled from one to three times a week, depending upon the severity of the anxiety. The therapist should discipline himself to keep his appoint-

ments on time and then he can expect the same behavior from his patient. A patient who arrives late should be dismissed at the end of the scheduled hour and if lateness continues to be a characteristic of a patient, it may become an important point for discussion. A number of patients will show reluctance at being dismissed on time and they may employ various techniques to prolong the hour. Such behavior may prove to be most informative to the therapist and later can be used for purposes of interpretation.

The interview, insofar as possible, should consist of spontaneous productions by the patient. It is a time when the patient can talk about any and all things that seem important to him and the therapist guides the conversation only upon special occasion. This does not mean that the doctor sits in a passive manner, making no response and asking no questions. The doctor upholds his end of the conversation, but his questions ask only for elaboration and clarification of material already mentioned by the patient. Rarely are new topics introduced by the doctor and accusatory questions are to be avoided. An accusatory question is something like, "How do you get along with your husband, Mrs. Jones?" The answer to such a question is worthless most of the time. If the doctor feels he needs to know such information and cannot wait for the husband to be introduced into the conversation, he can sometimes open up such a line by asking about the husband's health, job, age, etc., and then see what Mrs. Jones does with the topic. It is better to wait, however, and if Mr. Jones is never even mentioned in three or four sessions, the doctor has no problem in figuring out how important Mr. Jones is to his wife.

Every moment of an interview need not be occupied by conversation and the doctor need not feel called upon to fill in pauses. When a patient stops talking it is better to sit in silence for a bit than to interject some observation simply to keep up

the stream of talk. The doctor who can control his impulse to restart the conversation right away will be the recipient of a lot of information that would have otherwise been left unspoken. So often a patient is pausing a moment to gain the courage to speak or taking time to formulate a statement, but before he can commence talking he must answer a question that is completely unrelated and a new conversation is started; a golden opportunity may have vanished. There is another reason why a period of silence should not be terminated too soon. Some patients feel themselves called upon to restart the conversation and often the longer the pause continues, the more their anxieties build up. They may and often do blurt out something that was on their minds all the time but never would have appeared in the conversation had not their anxieties forced it out. With such a person a pause is not utilized to frame a good reply and when the silence becomes oppressive to them, they will often end it with the first thought that offers itself. This poorly censored thought is sometimes heavily laden with emotion and may provide the opening to the real conflictual material that has been lying buried.

Mrs. A. kept her appointments promptly on time. As the interviews progressed there were occasions when the psychiatrist was delayed from five to ten minutes. Mrs. A. showed resentment when she was kept waiting, voiced a curiosity about the patient who had preceded her, or she remarked about how busy all doctors were and how little time they had. She produced little spontaneous conversation and there were many long periods of silence. These were usually terminated by some flippant remark or she would return to how miserable she felt and not infrequently she would weep. As the end of the hour approached Mrs. A. almost always became talkative or would light a cigarette and consume an extra five or ten minutes while she finished smoking. She had a habit of asking some difficult, involved ques-

tion as she was preparing to leave, though she may have spent most of her allotted time with trivia and silence. She was put on a once a week schedule but soon supplemented this with telephone calls. Her calls invariably came at a busy time of day and she propounded insoluble situations for discussion. Such behavior was evidently for a purpose and was carefully noted. A desire to control the therapist, to inconvenience him, and make him late for any succeeding appointment. She seemed annoyed that any other patient might get five or six minutes extra time. The therapist's good opinion was apparently important to her for she was always on time and never became openly critical or gave the therapist any indication that she was dissatisfied with her treatment.

D. The Non-Critical Permissive Attitude

A therapist's ability to listen and the freedom he gives his patient in choice of topics must be supplemented by an ability to remain entirely uncritical of anything a patient may reveal about himself. Very few patients are willing to talk much about themselves if they feel the doctor is sitting in judgment. Many people suffering from psychiatric disorders are struggling with unacceptable ideas that may be almost unthinkable, let alone spoken to another. Embarrassing sexual confessions, ideas of lust and greed, hostility amounting to hate and death wishes, may be recognized by the patient as he proceeds in therapy and such thoughts can only be expressed in very special situations. The patient must be sure that his doctor will not reject him. He must feel certain that any confession will be met with understanding and will not be belittled as foolish or met with censure and a lecture. Ideas of inadequacy, fears of failure,

doubts about manhood, desires for excessive dependency, are all difficult things for anyone to discuss, let alone a person who is being torn by anxiety because of such feelings. A statement from a doctor that it is safe to tell him anything rarely produces results and only intimates that the doctor suspects some unsavory characteristics. A permissive attitude is an attitude and not a statement. It is acquired through experience and background and is felt by each new patient only after he has had an opportunity to test the doctor. A patient may be satisfied with his testing at the end of five minutes but another patient may take five months. This is what a patient has felt when he says, "I like Dr. X, I feel I could talk to him and tell him things." No amount of probing and searching through the history will produce the pertinent information that can be gained by a permissive attitude alone.

Mrs. A. quickly established a relationship in the treatment situation and as time went on seemed to feel the need of explaining her past history. The first several sessions were not too productive for she would mention some general fact about her past life and then seemed to feel no need of going on or elaborating. Her periods of silence became less frequent however and she finally felt enough at ease to stop her protesting and talk about herself. She admitted disgust for intercourse and wished her husband would never touch her again. She told of a life-long aversion to sexual matters and how she had acquired a reputation of being a spitfire and a prude. Boys, she said, didn't like her for she permitted no show of emotion and thought their clumsy efforts at love making were disgusting. She examined where these feelings might have come from and told at great length of her rigid training at home. Her father was a God fearing man who saw evil in every pleasure and in particular did he warn of the everlasting Hell awaiting those who tampered with sex. Mrs. A. then admitted her own lively interest in sex and recalled that as

a girl she longed for a sexual experience but was terrified by having such yearnings. She had experienced two or three such situations which were more or less normal in a person's development but to her they were events of great sin and her conscience bothered her.

Mrs. A. told of her unpleasant memories at home. She talked of her stern father who gave no love or warmth but always was ready with punishment or preaching. She admitted that she had grown to be ashamed of her father. She told of her mother who was too busy having children and fighting poverty to pay any attention to childish wants. Mrs. A. wept when she explained how she had resented the feeling that she was loved by her mother only when she was a good girl. She spoke of her rebellion of her treatment at home and how she commanded attention by "raising Hell" when all else failed. She admitted that her independent, aggressive attitude created many problems for her and won few friends but that she couldn't tolerate being ignored. People, to her, weren't going to like her anyway so better show them first that it was mutual and avoid any hurt feelings. She knew as a little girl that she was not going to buy love by becoming passive and compliant. People were going to like her for her own sake or not at all, but there was an ever present longing to be liked.

Mrs. A. also told of her fears of becoming an old maid. Boys showed no interest in her after a few dates. She was too independent and too brisk in her treatment of their amorous advances. She longed to be loved and wanted marriage but the years slipped along until she was in her late twenties and no proposal had materialized. She married finally after a brief courtship and in the treatment situation she found herself wondering if she had married because of love or because she was anxious to be married. The sexual part of her marriage was a failure from the first. She was frightened and repulsed by intercourse.

She feared pregnancy but yet was disgusted by a contraceptive device. She wanted her husband to be loving, kind, and gentle but was unable to show those qualities in herself. She finally admitted to her therapist that beneath her rejection of sex, she wanted a thrill out of intercourse and was bitter towards her husband because he didn't provide it. These feelings left her guilty and ashamed for she felt it was actually sinful to have desires for sexual gratification.

The permissive attitude of the therapist allowed Mrs. A. to get a lot of feelings "off her chest." These confessions helped her but at the same time the therapist was able to form a fairly accurate picture of Mrs. A. It became apparent that she had suffered from parental rejection, real or fancied and her behavior in life was in response to these feelings of rejection. Her formula was, "I am strong and independent, no one can hurt me. I give nothing of myself so no one has any power over me." This would have been all well and good if there hadn't been an equally strong desire to be dependent and to be loved. These cross factors were at war within Mrs. A. and causing much of her trouble. Her sexual life was unpleasant because of her rigid early teaching but also because she demanded that she be "made love to" without having to give anything of herself in return.

E. Allowing the Patient to Formulate His Own Thinking

A total concept, an entire situation can be contained in a brief flash of thought that might occupy a hundredth of a second. The same idea, if talked out, might take hours. Many painful or suppressed thoughts get mighty brief treatment when they remain in the realm of thought. Even if a problem is considered more at length by thinking about it, there still exists that nebulous quality of thought that does not demand the greater formulation that is required by speech. A person may for the first

time be forced to formulate his thinking. The uncertainties, the vague fears, the ill defined sense of shame, that may have been associated with the problem frequently disappear as a patient allows his thinking to clarify. It is not unusual for a patient to talk about his problems for an entire session and then announce that the doctor has helped him tremendously. Personal problems of a delicate or intimate nature rarely are discussed with friends or relatives and yet discussion is often all they need. How often a person feels the need to talk to someone and that feeling does not indicate that the person wants to listen to someone else talk. He simply wants to objectify his thinking so he can judge for himself. He will marshal arguments pro and con as he talks that never occurred to him before and he may be able to arrive at a decision. It is for this same purpose that the lonely peasant will talk to his dog, or lacking a pet, he may reason out his problem by talking to a stick or to his thumb.

Mrs. A. for the first time in her life was talking to someone about her intimate self. She felt safe in so doing for it had become apparent to her that she had been accepted and was liked. She remarked upon occasion that it was good to know that the therapist was going to be the same each visit. She also admitted to being concerned about creating a bad impression for she was telling things she had hardly dared think about before. The fact that she spoke these things, forced her to examine them and she discovered a lot about herself. She clarified many of her feelings for her parents. While telling about the advice to have a baby, she worked out by herself her rejection of her pregnancy and her mixed feelings toward the child. She was able to see the connection between her early teaching and her prudish sexual behavior. She discovered that she actually did long for people to like her and that she wasn't half as independent as she pretended to be. This type of formulation of thinking occurs when thoughts are spoken and especially when they are spoken

to someone who is supposed to be intelligent. It is only natural for a person to attempt to speak up to the level of his listener and in so doing, he may bring more intelligence to bear on a problem than he has ever used before.

F. Reflecting the Patient's Own Feelings

A patient may relate a traumatic incident or unhappy memory but stick to the bare facts and indulge in no expression of emotions. Some comment may be called for from the therapist when the tale is finished and frequently it is possible to reflect the emotions the patient has displayed but never voiced. Mrs. A. stated that her husband was always going fishing or golfing. During the tale it was obvious that she was annoyed. The therapist remarked when she had finished that she found her husband's habits difficult to accept. She responded with a flash that her feelings were even stronger and that she was downright mad about being left alone. She hastened to explain that she had no desire to keep her husband from going golfing or fishing. She said that she actually wanted him to go and enjoy himself. The therapist remarked that she seemed to have mixed feelings, that while she was angry with her husband for leaving she was also willing for him to go and didn't want to prevent him from having a good time. Mrs. A. acknowledged these conflicting feelings and showed a rising tension in her manner. Again it was pointed out that perhaps she had never identified her feelings before and now was having some trouble understanding them. She responded that she was having no trouble whatsoever and knew clearly that it made her angry when her husband left, but she couldn't state why.

The patient is usually encouraged to examine his emotions when the therapist identifies them. This is of much more importance than the simple recitation of events and is the essence of aeration. When pent up emotions are released a patient nearly

always feels better and may discover some genuine feelings that were only vaguely felt before. Mrs. A. had praised her husband's thoughtfulness, ambition, fidelity, etc., for several sessions. She had defended his right to relaxation and personal freedom but now she gave vent to full hostility. The more she talked the more things she thought of to criticize. She hotly denounced his ability as a lover, his seeming indifference, his optimistic outlook, his willingness to leave her alone, his lack of sympathy toward her illness, etc., etc. She remained angry until she got home and there she gave vent to her feelings again. It was a shock to her to hear her husband say that he had found it increasingly difficult to make love to an unresponsive stone pillar!

IV. Avoidances in Therapy

A. Interpretation

Interpretation is the form of treatment most often used by untrained therapists and perhaps the one least used by a trained therapist. The desire to explain to a patient the reason for his illness is often over-powering and great humility is needed to resist it. The novice begins to understand the futility of direct interpretation only after he has given a few dozen patients a clear concise explanation for their illnesses and has been met by total rejection or blank lack of understanding. The patient, after some such clear statement about the cause of his trouble, may be able to parrot it all back, showing good intellectual grasp but his symptoms may go merrily on.

There are a few points to remember before interpretation is attempted: first, if the therapist will always admit that his conclusions might be wrong, he is less anxious to press them onto the patient. An incorrect interpretation is exceedingly harmful. Each therapist should, while listening to his patient, build in his own mind a hypothetical explanation for the patient's dis-

turbance. He should be ready at any moment to discard or alter this hypothesis if new facts do not fit. This procedure keeps the therapist awaiting new material and his questions are designed to either prove or disprove his tentative conclusions. The therapist who becomes fascinated with his own formulation of the case will sooner or later be guilty of bending the facts of the case to suit his own ideas. The process of having the patient elaborate certain memories and then examine the emotions that accompany them, enables the patient to achieve his own interpretation which then can be discussed.

The therapist must also realize that the patient may be unable to see his problems because of an emotional block. Interpretation is useless until this block is removed and it will only be removed when the patient feels it is a safe thing to do. When a patient has talked out his feelings and examined his reactions, the need for further interpretation is small. Finally, to point out to a patient that he has homosexual leanings or that he is basically inadequate or that he harbors a deep hostility for his child may be an extremely foolish thing to do. Such energetic explanation may serve only to precipitate a more serious reaction. The recognition of such characteristics is usually unnecessary and should never be insisted upon in any circumstance unless the patient has in some way indicated that he is ready for such recognition. The symptoms a patient displays are his means of protecting himself from something that appears much worse. He will resist any attempt to make him relinquish his symptoms and if they are taken away from him, he may be left utterly defenseless.

With Mrs. A. it soon became apparent that she had deep dependency needs which she consciously rejected and refused to recognize. She had been furious with her father for not giving her open demonstration of love and now she was hostile toward her husband for the same reason. She longed for someone to

cuddle her but her fear of rejection would not allow her to show any demonstration of emotion. Yet she was seething when some action of her husband's indicated that he preferred anything to her. When her husband went fishing it was overt evidence that he would rather fish than stay home. With Mrs. A. it had always been "all or nothing" and if it was "all" then it could be felt and demonstrated any time. Moreover, love for her had to be tested at every opportunity. Her lover had to be on hand whenever she wanted him. He had to accept all of her behavior and accede to all of her demands no matter how trivial or annoying they might be. To refuse her most minor wish was, unconsciously, evidence of rejection to her and a flare of anger was immediate. Mrs. A. was an intelligent woman but to have explained to her that she got angry just because people wouldn't do what she wanted really would have upset her. Such an explanation by the therapist would have appeared as a very real rejection. Mrs. A. was continuing to behave as she had when she was a little girl where she had felt keen hostility when her parents had slighted her. She had reacted in an aggressive fashion that more often than not brought punishment down upon her and a moral lecture from her father. As she grew older the resentment and hostility became more and more buried and these feelings would not fit with her moral and ethical code. The outward show of anger had to be curbed to fit with acceptable adult behavior so all that was left was an unexplainable surge of unrecognized feeling that released itself in undirected anxiety with frequent bursts of misplaced anger. Interpretation of this material prior to having Mrs. A. work through it, would have been useless. Actually, an interpretation would have been rejected as utterly without foundation.

The behavior that Mrs. A. displayed with her therapist was a repetition of what she had done with her father and with her husband. She responded quickly to the understanding and

acceptance the therapist gave her, but she tested him at every opportunity. She made impossible demands, she sought extra privileges and she expected complete agreement. Her habit of keeping the therapist over time caused a situation at the end of every hour and nearly always she left her interview in an angry frame of mind. She announced repeatedly that she felt she was being thrown out at the end of her hour though invariably she had maneuvered to extend her time from five to fifteen minutes. She was unable to see that she had, by her own efforts, created an unhappy situation for herself. Innumerable bits of behavior served to illustrate her character. She found the office too warm one summer afternoon and suggested that the session be moved to the lawn. When this suggestion was not immediately accepted, she became furious. Characteristically, she did not vent her anger directly and said nothing about it to the therapist, but the sudden rise in her coloring, her facial expression, her clipped, terse replies and use of thinly veiled sarcasm on all topics gave evidence of her feelings. The therapist reflected her attitude and she admitted the sudden rise in anxiety and her feelings of anger. She was unable to explain her anger and became much more tense when she tried to think of a reason why she might be upset.

Interpretation can be a two-edged sword and a very sharp one. It would seem that Mrs. A. should have been able to see the reason for her behavior but the very nature of her conflict made the recognition of her unhappy traits an impossibility. If direct explanation of her behavior had been made too early, she would have countered with excellent rationalizations and the therapist would have found himself in the position of attempting to convince his patient of something she couldn't accept. Furthermore, it would have appeared to Mrs. A. that the therapist had a poor and unwarranted opinion of her; in other words, Mrs. A. would have felt that she just wasn't being

understood and she would have retreated even further into the very characteristics she was attempting to alter.

Insight into self comes from within and only time, discussion, self-appraisal and willingness to work with one's problems will achieve insight. As treatment progressed with Mrs. A. more and more opportunities arose where she was called upon to examine her feelings in response to the therapist. Finally, one day as she was lighting a cigarette at the very end of her hour, she paused and announced that she knew what she was doing. She flushed, blocked and was unable to continue. She left the office quite angry. The next session was filled with resistance and hostility and no mention was made of the episode of the cigarette until the end of the hour approached. She was unable to hold back her admission and told how again she was experiencing a desire to prolong the hour. She said that knowledge of such a desire was a revelation and she detested herself. She viewed such an impulse as being cheap, selfish and wholly despicable. The next few sessions found the therapist and Mrs. A. exploring much of her past behavior in the light of her new knowledge. Time and time again the theme was encountered. She found the reason for her anxiety and unexplained anger in dozens of situations that previously had defied explanation. She made a grudging acceptance of her unwelcome traits and stalled several times. Repeatedly she made efforts to switch the emphasis so that it would appear to be the therapist who had such ideas of her and then she would return to her anger and denounce the whole affair. New life situations continued to present themselves that bore out the theme and as these were explained, it became easier and easier for Mrs. A. to understand her reaction. Finally she faced her problem more squarely and brought her intelligence to bear upon it. She started on a hunt through her past experiences again in an attempt to explain how such an unhappy trait ever came into being. She identified the similarity of her present

behavior with her behavior as a child and was able to correlate it with her marital difficulties.

B. Advice and Information

The physician who accepts the role of a good listener will not have much difficulty about giving advice. Advice cannot be given until the physician is certain that the patient can carry it out and that it is what the patient wants to do. This means discovering what the patient's feelings are about each situation that seems to call for advice. The patient probably will have worked out his own decision by the time he has talked through his feelings and this is, of course, one of the aims of treatment. Questions and requests for advice are best turned back to the patient even though the therapist thinks he knows the proper answer.

1. Information, Not Advice

Information is entirely different from advice and is not based upon personal opinion. The giving of information is an important part of treatment and should be utilized whenever it is indicated. Information about the effects of masturbation, the significance of the menopause, the meaning of a pounding heart, etc., may go far in relieving anxieties. A patient may feel greatly relieved to know that others have unacceptable thoughts or that a difficulty in concentration in itself is not a sign of insanity. Information about study habits, methods of relaxation or other daily activities frequently is helpful. A patient may be found to be laboring under gross misinformation and to give him the truth is sensible.

In the case of Mrs. A. advice was held to a minimum. The most frequent request for advice was what to do about her husband. She seriously considered leaving him upon more than one occasion and wanted guidance. Her questions were turned back to her and direct advice was never given. Mrs. A. needed

quite a lot of information particularly about sexual matters. It is in such fields as this that reassurance can be effective. Reassurance is never platitudinous but is always based upon actual knowledge that the therapist is able to give. Vacuous well wishing and ill founded predictions are harmful; certainly they are not acceptable to scientifically trained physicians and therefore have no place in psychotherapy.

V. Redirection of Energy

Many patients are so absorbed with conflictual matters that they have little or no psychic energy for normal, healthy pursuits. Such people are preoccupied with their problems whether they are aware of their problems or not. They profess no outside interests, nothing seems to appeal to them and they cannot find the energy to do the things they are forced to do. If such a condition continues over a few years, a habit of living is formed and the person's capacity to enjoy himself is seriously curtailed. A void is formed in the art of living and it is filled with difficulty. The person has few pleasant associations, he is able to forget himself only for brief moments, he has few past experiences to build upon, so life is apt to appear dull and pointless. Such people can only look with envy upon the crowds having a good time at a ball game or they view a person with a hobby as completely beyond comprehension. The creation of an interest outside of one's self is not an easy task when all available energy is being used internally. To advise a patient to start a hobby or join a club is good advice but exceedingly difficult for him to carry out and he may fail even though he tries. A patient freed from internal preoccupation has the energy to expend elsewhere but he may need guidance and suggestions simply because he has no ready-made place for this new energy. As pointed out, he may have to start from scratch and his efforts may be floundering and he may retire into his shell. The

creation of diversions, outside interests, etc., is usually possible only when preoccupation with self is reduced.

Mrs. A. certainly had no outside interests, everything she did was referred back to herself and her own problem. She was absorbed in seeing to it that those about her gave her approval and when they didn't seem to do so, she was filled with anxiety and unable to enjoy anything. She was never aware that she was continually creating little test situations that were sure to fail and she never understood that a normal difference in desires did not present a rejection. She could, at a football game, ruin her entire afternoon by making some annoying little requests of her husband that he would postpone or ignore. If he jumped to fulfill her desires, she was content for a while but would be unable to keep from testing again and ultimately was assured of running into trouble. The game held none of her interest; her problems dominated every moment of her thinking.

Mrs. A., at the beginning of treatment, had no chance of establishing an outside interest. She had been so advised on many occasions but every effort had been a failure. She had tried to go fishing with her husband but had absolutely no interest in fishing and after dropping her fly in the stream a few times she became bored and returned to the absorption of her unhappiness. The fact that her husband was joyously wading up the stream and leaving her didn't improve her disposition either though she would have rejected any effort to help her.

When Mrs. A. began to lose her anxiety and become aware of her behavior, she actually found herself with nothing to do. This void had to be filled and many suggestions were made and discussed. Participation activities were encouraged along with group spectator entertainment. She found it slow going but over a period of time formed some knowledge and background for a few interests. She then began to spend much of her treatment time talking about her new found knowledge. For the first time

in her life the impression she was creating on others was not the most important thing. She still retained many of her old habits but they became modified to such a degree that she was freed from her chronic symptoms and was able to accept her associates as potentially friendly people.

VI. Termination of Treatment

Every therapist should be able to determine when he has accomplished all that he is going to accomplish. This means that some treatment goal needs to be envisioned and kept in mind through the entire course of therapy. When this goal seems to be achieved, a re-evaluation can be made but a decision is in order about the continuation of treatment. No living person can be totally free of problems; therefore no therapist is going to carry a patient to the point that no more problems exist. It is conceivable that a patient could continue under treatment for life, each session bringing in his immediate concerns for discussion. So there is a very real problem about when a patient has achieved maximum benefit. There is no rule to follow but in a majority of instances the patient himself will indicate his desire to discontinue. The therapist then must decide whether this is the time to stop or is he dealing with a resistance and a desire on the part of the patient to escape. The latter situation is one for identification and discussion. A genuine readiness to "go it alone" must be encouraged.

The irradiation of symptoms is often a treatment goal. A patient who has come in with symptoms of anxiety wants relief and when it is achieved, he may be ready to go on his way though he has gained no understanding of the cause of his anxiety. Another type of patient may have had presenting symptoms but as treatment progressed, there appeared deeper, more complex pathology and the treatment goal is changed considerably. Still other patients are so cemented in their psycho-

pathology that symptomatic or temporary relief is all that can be hoped for. A decision of when to terminate can be a "knotty" one, but can be eased by evaluating expected results and by careful appraisal of the potentialities of each patient.

A therapist must keep in mind the fact that a patient is going to live by himself some day and struggle with his problems as best he can. It is therefore a serious mistake to underestimate a patient's ability to take care of himself. A therapist can become so accustomed to playing the role of father and teacher that he can't visualize the patient getting along without him and continue the patient in treatment overlong. Most people, once a problem is identified then clarified and understood, want a chance to handle it themselves. They should be given this chance when they ask for it. The methods that patients use to indicate their readiness to terminate are quite variable. Some just never return, some inquire if further sessions are necessary, some begin to miss appointments or show an increasing reluctance to bring up new problems. Others flatly announce that they feel fine and see no reason to come back. The therapist, if he has evaluated his case correctly, is in a position to know what is happening.

Mrs. A. asked one day if the therapist felt that the cause of her difficulty had been discovered. The question was turned back to her and she stated that she felt she understood why she behaved as she did and cited an instance or two where her new found knowledge had saved her from a show of temper. She said her symptoms had abated greatly and she felt that the rest was up to her. She discussed the problems confronting her and how she was going to have to watch herself to keep from creating test situations. She acknowledged the need of outside interests and pointed with pride to her efforts in that direction. Her desire to terminate treatment was apparent and the amount of improvement was deemed satisfactory. Mrs. A. left treatment

with many difficulties awaiting her but with a resolve to meet them and a fair assurance that she possessed enough knowledge to avoid a repetition of her past misery.

VII. Conclusion

In summary, psychotherapy is certainly an art, but it is an art that is based on sound scientific training. No one can hope to do psychiatric treatment without knowledge of personality formation and development or without training in psychopathology. The days of fatherly advice and stern admonitions are long since past and may they never return as methods of helping people with psychiatric problems.

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Chapter XXII

THE THERAPEUTIC
VALUE OF
PSYCHOANALYSIS

By

MILTON R. SAPIRSTEIN, M.D., Psychiatrist
Psychoanalytic Clinic for Training and Research
Dept. of Psychiatry, Columbia University, N. Y.

Chapter XXIII

THE THERAPEUTIC VALUE OF PSYCHOANALYSIS

By MILTON R. SAPIRSTEIN, M. D. Psychiatrist

Psychoanalytic Clinic for Training and Research

Department of Psychiatry, Columbia University, N. Y.

(Psychoanalysis, as a method of therapy, is growing increasingly difficult to define in simple terms. Since its inception by Freud the outstanding characteristic of psychoanalysis has been its dynamic quality. This dynamic aspect has to a large extent been the basis of therapeutic effectiveness.) At the same time, it has manifested itself in constantly changing theoretical structure and repeated modification in the more practical aspects of its application. For more so than in any other method of therapy, psychoanalysis has shown capacity for growth, for admitting its own mistakes and in finding common points of reference with other sources of learning. In its apparent weaknesses, lie its greatest strength. The capacity of psychoanalysis to grow and to meet individual needs of its patients offers a dynamic maneuverability which is evidence by its enormous growth as a therapeutic weapon since its inception. Not only was psychoanalysis begun by Freud but many of its modifications were started by his very facile but at the same time well-disciplined and self-critical approach.

(Let us begin our survey, therefore, by a historical approach to the problems of defining the psychoanalytic method.)

A. Tension or "Plumbing" Theories

Psychoanalytic theory began with the description of "Anna O." by Joseph Breuer and Sigmund Freud.¹ They made the significant observation that a past traumatic event, "a hurtful experience which the patient did not remember," was the basic factor in the production of her neurosis. This opened the era of *Tension or Plumbing Theories* in which a repressed memory or an unresolved emotional conflict was considered the basic core of neurotic behavior. Stimulated by this discovery, Freud began to devise techniques for exploring the unconscious. He gave up hypnosis as inadequate, found "waking suggestion" (advising the conscious patient) ineffective, and finally settled on free association and dream analysis as guides to the unconscious. It was soon discovered that the *abreaction*, or reliving the original traumatic event, had an enormous therapeutic effect on the patient. Thereupon, all efforts were directed toward bringing into consciousness the repressed memories, feelings, and strivings, which were disturbing the patient.

Using these new techniques, Freud embarked on some of the most brilliant and ingenious studies of human development ever undertaken. In his earlier cases, when dealing with hysterical females, he thought he found repressed adult sexual factors as the almost invariable basis of the emotional disturbance. Further studies, however, revealed that a hurtful sexual experience which occurred in adult life was in itself insufficient explanation for an emotional disturbance and that the cathartic method of the exposure of the unconscious did not necessarily succeed when based on this assumption alone. Freud, still operating within the framework of the repression of adult sexual hurt as the cause of neurosis was, therefore, forced to seek a broader base for his theory of the neurosis.

This he accomplished by formulating the "*libido theory*"

which expanded our ideas of sexuality and led to the following developments:²

1) The libido theory, for the first time, described childhood sexuality in our culture. This gave us a novel and dynamic view of human sexual development, and the nature of its repression. This evolved into the theory of the *Oedipus Complex*.

2) The libido theory also described the possibility of sexual feelings as arising from other places than the genitals. Freud revealed the existence of erotic sensations deriving from the mouth, anus, skin etc., thus broadening our understanding of the variability of sexual feelings.

3) Freud also demonstrated, within the libido theory, that feelings of homosexuality was greater than was formerly believed, and the unconscious manifestations of homosexuality among neurotics was frequent. This took the phenomenon of homosexuality out of the exclusive domain of perversion and made it a more dynamic force in the study of normal and neurotic human behavior.

4) Freud also demonstrated that many activities which were apparently unrelated to the sex drive contained sexual components and meaning for the patient. Thus, he found that athletic, artistic or intellectual pursuits—or other emotions, such as rage, fear and grief—were found to be involved in the sexual impulse.

5) As part of this new formulation, Freud conceived of the *libido* as a chemical, life-giving, energizing force, which if unliberated, could lead to a damming-up of emotions and consequent production of anxiety. The effective use of this libidinal energy became the basis of his *pleasure principle*. The release of this energy through unfolding unconscious repressions became the goal of psychoanalytic therapy.

All these extensions of the sexual concept gave new scope to Freud's attempts to expound the unconscious repressed sexual fac-

tors which produced the neurosis. However, new elements were constantly coming under examination — especially the nature of the repressing forces within the individual. When he began to study these more fully in *The Problem of Anxiety*³ he came to the conclusion that repression was not the cause of neurosis, but its result; and that the individual originally “repressed” because he was anxiety ridden. However, so much valuable work had been done, that even though it had been based on a limited premise, most of the factual material remained intact. And even though the treatment of emotional difficulties by *abreaction* or Catharis was not always successful, within its limits, it produced results. As for the general public, the original concept of repression as causing neurosis has always remained Freud’s most startling contribution, and many literary and dramatic interpretations of psychoanalysis still utilize this single device as “psychoanalysis.” Also, for many confused people, the possibility of finding salvation through fulfillment of instincts offered an attractive justification for “uninhibited” behavior.

The cathartic method was also appealing because of its obvious roots in earlier and more primitive methods of therapy. Many primitive tribes used the “casting out of evil spirits” as the basis for therapy, while blood letting and intestinal purging were still very much part of the medical treatment throughout the nineteenth century. The evacuation of pus from a festering wound, for instance, and the subsequent healing has always been a dramatic demonstration of surgical therapy. All of these “cathartic” methods were seemingly applied by Freud to the sufferings of the human mind through free association and *abreaction*.

The limitations of the “cathartic” method as an exclusive method of therapy became apparent early in the development of psychoanalysis. Some analysts including Adler,⁴ began to belittle this aspect of psychoanalysis and placed increasing em-

phasis on the more reality-oriented assertive or competitive aspects of human development. Others, like Jung,⁵ went in the opposite direction and increased their explorations even further by extending them into deeper levels of unconsciousness, seeking to solve many problems of human behavior by the semi-religious concept of a racial or collective unconscious. On the other hand, Melanie Klein⁶ and her followers in the English School sought some resolution of the inadequacies by an even more intensive exploration of the earliest pre-oedipal years of the child's development.

B. Conflict or "Warfare" Theories

Freud attempted to resolve some of the limitations of his earlier theoretical formulations when he opened a new era in psychoanalytic theory with "Beyond The Pleasure Principle."⁷ With this work he introduced the conflict of opposing mental forces, the life instinct versus the death instinct, Eros versus Thanatos.

This originated the psychoanalytic study of internal conflict, another apparent source of *the neurosis*. Obviously, if instincts were repressed, there were powerful intra-psychic forces operating to accomplish this. New mental mechanisms came under observation, and in the book "Ego And The Id,"⁸ Freud departmentalized the human mind into three interrelating components, the id, the superego, and ego.

The *id* became both the generating source and reservoir of infantile instinctual libido and its chaotic striving which was a constant threat to the organism—the repression of which caused *tension*.

The *superego* was visualized as an internal watchdog or conscience whose values were derived from the pressures of early childhood when the parents and teachers inculcated the child with social values and taught it which impulses were unacceptable to its environment.

The *ego* was considered the integrating contact of the individual with the outside world, attuned to the instinctual demands of the *id*, on one hand, and the culturally determined self-punitive regulation of the *superego*, on the other hand.

The study of these internal conflicts became the task of psychoanalytic theory. Many new contributions began to appear—particularly in the field of character analysis⁹ (Reich) and the study of the total personality¹⁰ (Alexander). Anna Freud described defense mechanisms, other than repression, in the “Ego and Its Defenses.”¹¹ In addition, external or sociological factors were increasingly incorporated into the newer theories.

It was becoming increasingly apparent that the *ego* had functions other than the mere repression of instinctual impulses. It had a hand in adapting the personality to a real world. But this aspect of ego-functioning was slow to achieve recognition since earlier analytical efforts were built almost exclusively on repression of instincts within the individual. Nevertheless, new light was being thrown on the nature of repression. It was becoming clear that repression itself was caused by internal conflicts and that these conflicts were three-way battles between the *id*, the *ego*, and the *superego*.

At first, this internal struggle was visualized as the primary source of neurotic behavior; with tension and repression considered to be the result of a clashing of these unconscious forces. Later, however, these *internal* conflicts were no longer regarded as completely decisive and the analysts turned their attention upon *external* conflicts—to what extent cultural and environmental factors were effective in the production of neuroses. Associated with this change in orientation, then followed an enormous impetus to the study of the ego psychology factors in the production of neurosis.

The original concept of *superego* also expanded when it became apparent that other functions were served besides the

simple repression of unacceptable inner impulses. Its importance to the outside world was crystallized in the concept of "ego-ideal" and the "idealized image" (Alexander, Horney).¹² Thus, the superego became split into two forces; first, a self-punitive force which constantly warned the *ego* not to submit to its instinctual drives; and second, a force which controlled social aspiration, ideals, and common goals with other human beings.

With these developments, less emphasis was placed on *historical reconstruction* (patients' past history), and more attention was focused on what was happening in the analytical office—(*transference phenomena*¹³—relationship of patient to doctor) and in the realistic world in which the patient lived. As an extension of these newer orientations, several authorities^{12 14} began to reject the entire basis of the *libido theory* and offered other therapeutic systems revolving about character structure, interpersonal relationships, social and inner conflicts—rejecting almost completely the original basis of psychoanalytic theory.

These newer formulations began to orient themselves about external conflicts and the struggle of man to adapt himself in his complex human relations to a cultural setting. This has since become known as *character analysis* as distinguished from *instinct analysis* (libido theory). The sexual factors in these newer theories began to fade into the background and the reconstruction of childhood experiences were considered less significant.

Most analysts, however, have found these modifications unacceptable since they reject too much of a carefully-built foundation, which while it had weaknesses, was still capable of expansion.

The *conflict theories* of neurosis, whether oriented in libidinal or cultural terms had valid application and were close to the understanding of many people. They offered an obvious parallel to previous conceptions of internal and external conflicts as the causes of emotional problems: good versus evil, God versus the

Devil, life versus death, culture versus the individual, the vested interests versus the exploited, masculinity versus femininity.

C. Adaptation Theories or Evolutionary Method

Almost from the very beginning, Freud entertained a third approach to the understanding of neurotic behavior. More functional than others, this approach was based on levels of fulfillment or the attainment of a mature personality. This was a more evolutionary point of view, influenced by Darwin's contributions in biology and Frazer's work in anthropology.

Within the framework of the libido theory, Freud conceived of the mature personality as one which achieved full genital expression in adult sexual activities. He described lesser levels of adaptation as based on fixations or regressions to the immature methods of sexual expression—those experienced at certain stages of infancy and childhood centering about the oral, urethral and anal zones.¹⁵ Neurotic phenomena then were classified according to the levels achieved by the growing child. This theory was later refined by Karl Abraham¹⁶ in much greater detail. Basic maladaptation was considered as an inability of the individual to outgrow its infantile (or preoedipal) sources of pleasure and achieve the genital level during the period of attraction to the parent of the opposite sex—*oedipus conflict*. All neurotic phenomena were described as an outgrowth of this crucial conflict, and the subsequent failure of the individual to achieve his greatest potentiality of development.

This concept of the neurosis was to a large extent derived from observations of the regressive behavior of patients under analytical treatment, and proved fruitful. The fact that patients were capable of reenacting many infantile attitudes under the care of the analyst (transference phenomena), gave new insight into the nature of the child's dependent attitudes.

New studies of immaturity and the nature of the maturing ego

began to emerge,—and the developing process of infancy came into the limelight. The nature of the child's dependency upon the parent and its effect in weakening the *ego* were critically examined. Ferenczi¹⁷ carried these ideas further in "Stages In The Development of the Sense of Reality," in which he described the nature of the "magical" dependency of the child and the mental mechanisms associated with its outgrowth. Rado¹⁸ then described the importance of this system of attitudes in the relationship between patient and analyst and the similarity to the therapeutic process in hypnosis. He subsequently developed these ideas into new principles of analytic therapy. He began to unfold a new psychoanalytic theory based on levels of integration—somewhat apart from the framework of the libido theory—and based on biological adaptation for pleasure and survival.

Erich Fromm¹⁹ applied those newer ideas to the understanding of the nature of religious motivation and human relationships and clearly defined many of the cultural drives which drove people into submissive attitudes toward authority. The first systematic attempt to find theoretical structure for these changing ideas was undertaken by Abram Kardiner in his studies of the traumatic neuroses of war²⁰ and in his anthropological investigations.²¹ From these emerged an emphasis on dynamic adaptation and the disturbances of function, rather than the vicissitudes of instincts. The emphasis slowly shifted from the philosophical "why" to the more physiological "how."

The Freudian concept of the attainment of the mature "genital personality" and the fulfillment of man's capacity for pleasure and achievement offered many comparisons to earlier philosophical formulations. Plato's "good man," Aristotle's "the function of man," Spinoza's emphasis on the realization of man's nature by the use of his powers and Spencer's concept of the biological and social evolution of man—all contained similar points of view.

All of these changes in psychoanalytic theory have had their effect on the practical aspects of psychoanalytic treatment. Many innovations are constantly appearing which we will try to clarify.

The Therapeutic Value of Psychoanalysis

The therapeutic process of psychoanalysis has, therefore, undergone many modifications since its inception. Basically, however, it remains an intensive reconstructive technique for the exploration of the defective adaptation which is the cause of the neurosis. In addition to the more intellectual aspects of such a reconstruction, there is the powerful impact of the therapist, as such, on the patient (transference relationship). The handling of the transference relationship has undergone considerable change recently. In addition, it has been possible for psychoanalysis to slowly incorporate into its structure many of the positive values of other types of therapeutic relationships. This broadening scope of modern psychoanalysis can perhaps be best described from the perspective of the patient—who sees his physician in many roles in the course of analysis. This depends not so much on the behavior of the analyst as it does on the fluctuating needs of the patient.

Let us outline some of the roles which the analyst is capable of assuming in his therapeutic relationship to the patient.

1. The Analyst As a Friend

Mere contact with another sympathetic human has always been a powerful therapeutic influence. Many neurotic individuals have driven themselves into such isolation that they have had no opportunity to air their problems to a friendly listener. In this capacity, the analyst serves the same function as a good friend. Successful analysis, however, must slowly replace this relationship with outside, healthy social contacts.

2. The Analyst As An Idealized Parent (or God)

In this type of relationship, the analyst is transformed into a substitute parental figure and all of the magical expectations of such a relationship come into operation. Under these circumstances, the analysis takes on the aspect of a confessional and the transitory alleviation of symptoms which may take place do not differ from that obtained from any "magical" cure; church confession or Christian Science. Occasionally, this temporary recession of symptoms may serve a useful purpose, allowing a free interval for the development of new capacities. Usually, however, new capacities do not develop; the symptoms return and then considerable hostility rises against the parental figure who has failed to fulfill the inordinate expectations (negative transference).

Many of the most potent temporary therapeutic effects of this nature are accomplished by old-fashioned hypnosis in which the patient completely submerges his own individuality to that of the hypnotist and through suggestion gains confidence and strength.

3. The Analyst As a Permissive Parent (or Democratizing Force)

This type of relationship is one in which the patient becomes dependent on the analyst, grows up under his protective wing, develops new techniques of adaptation, eventually assumes a democratic relationship with the analyst, and departs as an improved personality. This is the emotional reeducation of Alexander, French et al.²² Usually, in such a relationship, the patient, for the first time, comes into a dependent role where he is not hurt or humiliated. The authoritative figure, in contrast to his parents, takes a more permissive, accepting position and this attitude spurs the patient on to new achievements without

fear of punishment or reprisal. All of his infantile guilts may be resolved as he finds an ally who is not condemning. With this new experience, the patient can then come into healthy relationships to sustain him outside of the office. With healthy personal relationships and new capacities for independent functioning, the originally over-inflated image of the analyst slowly becomes deflated and the patient can then function on his own.

None of these various types of personal relationships with the analyst need be on a verbalized or intellectualized level to be effective. They are primarily emotional experiences which may or may not be analyzed, and their counterparts are frequently seen outside the analytical office with friends and family in life situations. By themselves, they cannot be the basis for a completely controlled therapy, although they do account for some of the improvement.

Let us discuss the more intellectual (insight) aspects of psychoanalysis.

4. The Analyst As An Efficiency Expert

One of the most useful aspects of analysis is introducing the patient to himself. Disturbances in flight or withdrawal, disturbances in integrated activity, disturbances in dependency, can be analyzed and interpreted to the patient. The patient may be shocked with what he learns of his actions, the inefficiency of his behavior, the nature of his motivations, and his blindness to the social forces in operation. In this type of evaluation, dream interpretation strikingly demonstrates his own internal drives. Analysis of the patient's behavior in the office (transference phenomena) gives new insights into the character formation. This type of status quo analysis may be useful therapeutically and is the basis of the therapy of Karen Horney and her school. Unfortunately, however, for the average patient, the mere understanding of where his machinery has broken down

and what his internal conflicts are, may not be sufficient to cure all of his difficulties. He may find that although he understands what is wrong he is still unable to change.

5. The Analyst As An Explorer or Guide Into the Unconscious

This is the basis of the original Freudian therapy. The patient not only learns what is wrong with him but how it developed in the first place. He recaptures early experiences, sees their impact on his present disturbances in adaptation and relives them emotionally. He finds his dreams filled with the residues of early childhood experiences, obtains a long range view, learns how they affect his relationship with the analyst and the world. He becomes aware that his present behavior is a continuation of infantile conditioning and that it no longer serves a useful purpose in adult life.

All of the complicated symbolism of dreams, their relationship to present behavior and their origins in childhood serve to open up new areas of understanding for the patient. The unconscious methods of defense—the repression, sublimations, reaction-formation etc.,—are all exposed in the light of their origin, their impact on daily life and their effect on the relationship between the patient and his doctor.

The relationship between patients and analyst is frequently of crucial importance. It is a test-tube life situation in which all the personal difficulties of the patient will become manifest. Unresolved dependencies, hostilities, sexual drives, and the like, which disturb the patient in all of his outside personal contacts will come to the surface and are exposed to microscopic dissection under laboratory conditions. The analysis of these reactions (transference analysis) can provide the patient with some of the most striking insights into his own disturbed behavior.

All of the emotional reactions which he has been incapable

of expressing since childhood may find fulfillment in the transference relationship. This may have a powerful therapeutic effect for when the patient learns that he can be dependent, angry, or have sexual feelings toward the analyst and nothing catastrophic happens, he becomes liberated from many early fears.

The analysis of his resistances to the analytical procedure gives the patient new insights into inner psychic processes. Layer after layer of conscious attitudes are shorn off as all the defense mechanisms of the unconscious are exposed and directed. Each new insight is interpreted to the patient when the analyst feels that he is prepared to accept and integrate it into his newly found image of himself. The historical reconstruction may occasionally be aided by hypnosis, or the use of drugs.

This intellectual aspect of analysis may be profoundly therapeutic, for the mere process of thinking constructively is an important antidote to anxiety. When a meaningful "explanation" is put into the patient's hands, it may become an instrument for combating his emotional reaction, since it means a restoration of intellect over fear. It represents an aid toward self understanding, an additional weapon for the "ego." Such intellectual constructions, if emotionally acceptable to the patient, takes his neurosis out of the area of mysticism and gives him a greater chance in his battle for survival.

The intellectual structure which the patient uses to understand his neurosis need not be correct to be therapeutic. There are a multitude of "systems," analytical or otherwise, which patients have used to feel better. Many a charlatan can report good results with what seems to us, a farcical set of concepts. It is the function of analysts, however, to supply the most universally sound and therapeutically meaningful concepts toward the treatment of neuroses. An incorrect interpretation, however, at a critical moment is sometimes better than none and the theoretical system is frequently modified to meet the need of the pa-

tient, for the patient is going to use only that which fits his particular problem anyhow. The patient may pick up a most insignificant remark and use it very constructively, while he proceeds to disregard the brilliant intellectual gems of the analyst's therapeutic orientation. As long as the patient can use his insights to "learn" and reeducate himself for effective living, that is all that really matters.

How intensive should a historical investigation be? Analysts realize it can go on endlessly. There is no limit to the recollection of memories or to dream analysis. One can become lost in the morass of early experiences, and never get anywhere. There seems to be only one logical criterion—the past is important only in terms of its impact on the present.

The patient slowly learns that the analysis or the analytical relationship, in itself, cures nothing. For the life situation is the battlefield, where the victories are won. Analysis is not a substitute for living, but can be a useful adjunct. The relationship with the analyst may serve as a temporary crutch, intellectual insights may spur the patient on, but the capacity to build an effective life is based on his ability to translate these new values into a meaningful existence. Those neurotic attitudes of the past which have been resolved effectively concern us little. We selectively channelize the investigation of the past in terms of these persistent residues that are still hampering the patient in his daily life. Surgery has now reached the point where a diagnosis of appendicitis can be made preoperatively, the abdomen entered through a two inch incision, and the wound closed quickly. In former years, a complete abdominal exploration was performed for any complaint in that area, with an incision up to twelve inches. Psychoanalysis must become equally as efficient. We cannot afford to do "autopsy" on every patient before we heal his wounds.

It is a little ridiculous to expect every patient to relive the

whole history of the psychoanalytic movement as he explores his neurotic past. It is the function of the analyst to provide some framework for channelizing his thinking. There is much incontrovertible data concerning human behavior which the analyst can offer without disturbing the course of the patient's analysis. We cannot expect every patient to be another Columbus discovering America. While such an attitude of guidance involves certain risks and opens the possibility that the patient's subsequent associations have been "suggested," it is the only alternative to therapeutic chaos.

When a patient arrives in a panic with his whole world collapsing about him, we may not have time for complete historical analysis. If the house is on fire, we expect the fire department to put it out before they investigate the cause. Under these circumstances the analyst may defer his intellectual explorations until the patient's anxiety or his troubled life situation is under control. He may find it necessary to temporarily act like a friend, adviser or substitute parental figure.

6. The Analyst As A Conditioned Reflex Expert

In certain cases, when historical analysis, character analysis, and transference analysis, fail to achieve successful results, still another therapeutic approach must be tried. This approach is most necessary in the "masochistic" type of patient. These people are so conditioned to failure, so unable to conceive that they can function successfully, that they develop anxiety and withdraw before they even try. All of the intellectual insights cannot break what is apparently a fixed conditioned reflex of anxiety, for there is nothing more self-perpetuating than recurrent failure. In this type of patient, further intellectual elaboration, insight, or recapturing of infantile experiences may serve no useful purpose. They are "punch drunk" with failure and can learn to function only if they can be maneuvered into successful ex-

periences. Their new found success may fill them with increasing anxiety because they are so unaccustomed to it. They are so afraid of losing their success that they may have to destroy it in order to relax in a state of accustomed failure.

The resolution of this type of problem is the most difficult in psychoanalysis. It has to be handled in easy stages. The daily realistic activities come under detailed investigation and openings for possible successes are sought by both analyst and patient. It is understood that each new experience will, of necessity, be filled with anxiety. One can only hope that with each new experience, the anxiety will be lessened and the retreat be less hasty. It takes superhuman patience for both the analyst and patient.

Let us assume that the problem is related to seeking a job. After preliminary characterological, transference, and historical analysis are completed and all the psychological attitudes toward authoritarian figure elucidated, the patient begins his journeys. The first time he meets a potential boss, he becomes paralyzed with fear and goes into panic for six days. He goes back to job-seeking and even with the help of the reinterpretation, suffers the same panic. This time, however, his intellectual insight breaks through the panic after four days. The process is constantly repeated with consistent encouragement.

If all goes well, each successive experience may be associated with a shorter period of anxiety. Eventually, the successful patient may be able to control his anxiety during the actual interview with the boss and to get the job. If he is a model patient, he will eventually learn to handle the anxiety before he enters the interview. The patient has to be taught that the whole experience is like a prize fight, with an unlimited number of rounds. As long as he's in the ring punching, he can lose round after round and still win the fight with a single knock-out punch. One successful experience may mean more than all the failure

and if exploited to advantage, may change the course of a patient's life. To the man who has been unable to ride in subways—one successful experience may be enough to break the eternal cycle of defeat.

When this phase of the analysis is completed, another transition is necessary. The patient who was so innocent of psychological insight when he first arrived in the office and who subsequently became so clever at it, must learn to undo his intellectual control over his new found behavior patterns. These new patterns aren't worth much if they continuously depend on intellectual effort to be maintained. They must slowly be worked into an automatic emotional and spontaneous way of living. The analyst assists in this process by slowly retiring from his impersonal, intellectual role toward the latter months of the analysis, discouraging too great an intellectual effort and frequently taking a more friendly matter-of-fact position with less emphasis on further exploration of the unconscious. This is most effectively accomplished with the patient sitting up, and under the best of all possible conditions, such a patient leaves the analysis convinced that he can do as well as the analyst can in any further effort.

7. The Analyst As A Social Worker and Educator

Psychoanalysis has been in a position to influence every therapeutic factor surrounding the neurosis, with perhaps one exception—the lessening of environmental difficulties. Since the beginning of analysis, analysts have felt this beyond their province. This undoubtedly stemmed from the belief that all neurotic behavior was a continuation of infantile conditioning and that the environment was secondary. It is slowly being modified, since the impact of recent war experiences on psychiatrists has resulted in a more realistic orientation toward the daily adaptation of the patient. Although psychoanalysis can help the patient man-

ipulate his environment by greater insight and can channelize his attempts at personal reeducation, it is being performed less and less in a vacuum. Many an analyst is now willing to see members of the family, in an attempt to modify their attitudes in order to ease the burden of the patient's problems. This is especially important in complex marital sexual problems where the cooperation of the partner may be decisive.

8. The Physician As An Analyst

The increasing shortage of psychoanalysts, the rising awareness of the extent of psychosomatic disorders, the lack of psychiatric orientation and training in many of our physicians, have raised the problem of the need for almost every doctor to be analytically oriented. Especially in the field of psychosomatic disorders, it becomes important that the original separation between the psychiatrist and the physician be bridged. It no longer seems so important that one doctor listens to the heart or prescribes the sedative while the other explores the unconscious. There are many indications that in the not too distant future, many emotional problems will be handled on the general medical level, by the newer physician who will guide the medical course of the patient's problem. When this hoped-for goal is achieved, it will be possible for the specialized analyst to devote his major energies to particularly complicated cases, which need only the most intensive and expert handling.

In elucidating the therapeutic value of psychoanalysis, it becomes obvious that analysis is capable of opening to the suffering neurotic patient many channels of escape from his emotional problems. If the problem is a relatively simple one, the psychotherapist may limit his role. In case of a very complex problem, over a long period of time, the analyst may have to play many roles—that of a friend, reassuring parent, efficiency expert, historian, guide to reality, educator, physician, and others.

Every therapeutic device may be needed to fulfill even minimum expectations of recovery under difficult conditions.

It has become increasingly clear in recent years that there are multiple therapeutic approaches rather than multiple therapists. The modern well trained analyst is able to play a multiplicity of roles depending on the need of the patient. Only in this way can the patient eliminate the element of trial and error in search for the right kind of therapist to fit his particular problem.

The analyst, under these circumstances, decides which patients *must* be treated by deep exploration of the unconscious and which ones would be thrown into a panic or a psychosis by such a procedure. He decides which ones can only be treated by an impersonal objective attitude. He decides in which patients the environmental factors are predominant and in which the childhood conditioning is most significant. He decides which patients are inaccessible to any direct psychological approach and must be treated by hospitalization, shock treatment or brain surgery, before they can be made accessible to psychotherapy.

From time to time, individual analytical therapists have discovered that by limiting their approach, significant therapeutic results could be achieved in a shorter period of time. These briefer forms of therapy are all based on a singling out of one of the therapeutic factors in psychoanalysis.

It is true that some patients will improve without historical reconstruction, that a friendly warm-hearted doctor may do much good, and that an overbearing doctor may help his patients by powerful suggestion.

The problem however, is not to find "exclusive methods of therapy," but to evolve an approach that will combine all the therapeutic factors within the framework of psychoanalysis. Only then, can the doctor freely choose and modify his approach to meet the individual needs of the patient and thus become the

master of his technique rather than the slave of his "system." It is seen then that the road to "brief therapy" can come only through an awareness of all the alternatives, and a willingness to admit that there is no single road to mental health.

The problem now ceases to be a question of whether the analysis is deep or superficial and is rather concerned with whether it "works." Only an adaptation based on every possible available defense against anxiety, exercised in a fluid, flexible fashion has any hope of achieving lasting success.

Our task is not to "take away" from psychoanalysis, but constantly to add to it, in the hope that as we go along, more and more citizens can be helped to take their place as useful and mature members of the community.

In Conclusion

Psychoanalysis has gone a long way, both theoretically and practically, since its inception a little bit more than a half-century ago. Many gaps in our knowledge still remain to be filled and its usefulness as a therapeutic technique is constantly undergoing modification and expansion. The capacity of psychoanalysis to initiate and to undergo these changes and its ability not to remain a "closed system" is our major hope for helping the more neurotic members of society.

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Chapter XXIV

MENTAL HYGIENE AND THE FUTURE

AND

THE FUTURE

By

ALBERT C. VOTH, Ph.D.

Clarinda State Hospital, Clarinda, Iowa

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By ALBERT C. VOTH, Ph. D.

Clarinda State Hospital, Clarinda, Iowa

I. Public Apathy Toward Mental Disease

A pale, listless, elderly woman who had been confined in a mental hospital for many years once told the writer in a barely audible voice that she wanted to cremate her body. When asked why she wanted to do this her simple answer was "so that I can squeeze out of this place." Here was mental agony in extremis, utter human defeat, and a prototype of escape from unbearable mental pressure and frustration. A few minutes after this woman had spoken of her desire for self-cremation the dinner bell rang, and she slowly shuffled to the dinner table where she ate her meal in somber silence, as she had done for years. We blandly say, "where there is life there is hope," but this is not enough, for, in order that life may continue it must have a meaning through hope. To help supply the foundations for an open door to life, and the aspirations that give men a zest for living, must be the central purpose of any mental hygiene movement. Such a program concerns itself not only with conditions behind the bars of mental hospitals, and with public clinics, but also proposes to reach into the daily affairs of men where the beginnings of good and bad living are to be found.

The helpless and the weak are the responsibility of us all, but we who are well and strong have a standing tendency to

overlook this, especially when there appears to be no immediate urgency for our help or where we see no direct hope in anything we can do to alleviate a situation. Mental illness is a form of personal misfortune about which the average man has often felt entirely helpless in offering effective aid, and is therefore, often forgotten. Such forgetting plus ignorance has been the story of the care of mental patients. Always, however, where there has been human suffering there have been a few noble souls who have found ways—special ways—to light the paths of their fellow men in their extremities. So also, in recorded histories^{1 2} of the treatment and care of the mentally ill, we find in the past isolated individuals or small groups who raised their voice against neglect and abuse of those who had lost their morale and their mental faculties to plead their own case. As the humanitarian thinking of eighteenth and nineteenth century philosophers gained in acceptance an acceleration occurred in the demands workers in the field made for reforms, both in the care and in the concepts of mental illness. As early as 1842 an organization was formed in London called The Society for Improving the Conditions of the Insane. In the United States the National Association for the Protection of the Insane and the Prevention of Insanity was formed during the latter part of the nineteenth century, but had only a short life despite its ambitious aims.

Seen in perspective of the total problem these early altruistic individuals and small groups and societies could do but little more than kindle a light. The bulk of the stark necessity of caring immediately and continuously for the mentally ill has in the end always fallen to state or national institutions and hence has given such institutions by far the major authority in determining policies of treatment and care. On the grounds of practicality, economy, political commitments, and other reasons, such policies have not always been in harmony with some of

the more benign ideas that some well-meaning individual or society might have had to offer. This is not to say that state institutions cannot possibly function efficiently and at a top level of humaneness—many privately controlled mental institutions have undoubtedly been places of misery and evil practice—but the traditional crudities that arise from the mass handling of men have been more prevalent in large public institutions and, therefore, probably also more resistive to rectifying influence because of their mass origins.

II. Mental Hygiene Movement in America

In 1900 a young Yale graduate by the name of Clifford W. Beers became mentally deranged. In consequence he spent three years in mental hospitals in Connecticut, two of them private, and one a state hospital. When he finally recovered he decided to do something about the experiences he had had. His first move was to write the now famous book, *A Mind That Found Itself*,³ which was published in 1908. He did not rest there. His next move was to organize, with sympathetic support, The Connecticut Society for Mental Hygiene, and then in February 19, 1909, The National Committee for Mental Hygiene, still in existence today in greatly increased strength. The creation of this Committee marked the formal beginning of the mental hygiene movement in America.

The first thought of this movement was to remedy some of the bad conditions prevalent in the care of mental patients, but more than that, public enlightenment on problems of mental disease was also proposed. In the Committee's 1947 Annual Report⁴ Mr. Beers is quoted as having set forth in his book of 1908 the following statement: "A permanent agency for reform and education in the field of nervous and mental diseases is one of the great needs of the day—Though the improvement of conditions among those actually insane and confined should ever be an im-

portant factor in shaping the policy of such an organization, its most important work would be the waging of an educative war against the prevailing ignorance regarding insanity. Thus to cure the disease by preventing it, is the only effective cure known. The watchword of such an organization might well be the significant phrase: Mental Hygiene—" Dr. Adolph Meyer is credited with having suggested to Mr. Beers, at the time he wrote his book, the phrase "Mental Hygiene." What began as a small but virile movement not so long ago has now become of national and even international importance. In 1930 the first International Congress on Mental Hygiene was held in Washington D. C. Fifty countries beside the United States were represented at this meeting. In 1946 Congress passed the National Mental Health Act. In August 11-21, 1948, the International Congress on Mental Health met in London to effect, among other things, a permanent World Federation for Mental Health. An official bulletin⁵ announcing topics for discussion at the International Congress at London listed such considerations as: "Problems of World Citizenship and Good Group Relationships," "The Individual and Society," "Family Problems and Psychological Disturbances," "Mental Hygiene in Industry and Industrial Relations." Where Mr. Beers originally proposed an educative war against prevailing ignorance regarding insanity, his added suggestion of preventions as the most effective cures has logically led to those broad social and international interests under scrutiny in today's mental hygiene conferences.

In addition to giving attention to such broad interests, the educative programs launched by the mental hygiene movement have led to the establishment of clinics and agencies in many places to cope with specific local problems, both in a curative and preventative manner. This rather amazing nation-wide increase in well established clinics, many of them quite recent, and maintained by both public and private funds and given

moral support by many different public minded organizations, can hardly be viewed as just a mushrooming of some national fad. It represents a positive first step in our awakening, though still an inadequate awakening, to an appalling state of affairs, and with it bespeaks the conviction that something can be done to alleviate and prevent the mental distress of people. It is the beginning answer to our sudden realization that over half of all our hospital beds are being occupied more or less permanently by mentally sick people who are not only difficult to care for, but who are also a burdensome drain on our treasuries.

III. Continued Hindrances

A. No Hope of Cure

The social inertia that has allowed us to slumber so long while the demons of mental illness have danced around us has its backgrounds. We have been inclined in the past, and are still prone, to view insanity in the same fatalistic light that has counted poverty a social necessity, or an immutable aspect of human society. A few very forthright fatalists have from time to time even advocated the extermination of the mentally sick, and have thereby focused into a tough concept what so many of us have tacitly thought but have tendermindedly rejected. In our mental hospitals where the difficult problems of care and cure of patients becomes intensely first-hand, and sometimes very baffling, it is still quite common to hear pessimistic comments, not only from attending helpers, but also from doctors themselves—remarks such as: "This is a hopeless case, he will never get well again," "too bad he can't pass on," "I fear he's sunk." "We'll see him here again after he has been out awhile," etc. Such opinions leave out of thought the possibility of future curative discoveries and increases in the understanding of human behavior. And even more, they repeatedly run counter to many successes in cure when failures were predicted.

B. Biological Determinism

We have already made some notable strides in physical and psychological procedures in therapy, but much of the blame for our failure to care properly for our mentally sick and maintain an adequate level of mental health in the general population reaches deeper than mere public and individual indifference. In clearing a city slum there are often many deep-rooted social, political, and economic practices and sanctions that have to be attacked and modified. So also, our concepts regarding mental illness are still rooted in all kinds of sanctions and maledictions of the past. Much of our thinking about mentally sick people can be epitomized in that oft heard question so frequently posed in respect to undesirable human behavior, namely, "Can a leopard change its spots?". "Once insane, always insane" is the popular and easy answer in respect to mental illness according to the philosophy that poses the question about permanent spots. It is the answer that can come from a too strict acceptance of biological determinism in our thinking about human behavior, and makes the added error of insisting on a one-to-one comparison between man and the leopard. Genes have sometimes become nearly a stock in trade in the attempt to explain all the idiosyncracies and deviants of human behavior. We are still inclined to stress the idea that mental illness is mostly derived from established constitutional inherited structure, and therefore only rarely amenable to correction. In our atomistic, local-sign, way of thinking, and in our constant emphasis on strict norms of all kinds, biological and others, we have come to view the aberrations and irrationalities of the insane as foreign manifestations that mark him who has succumbed to them as a creature of a somewhat different breed and fibre, so-to-speak—likely of a somewhat lower order—than the rest of us. Society for ages has armed itself with all kinds of defenses against those offsprings of its

cultural and biological body which deviated to any extent from the so-called normal trend, but has seldom searched the precincts of its own collective make-up to account for the deviations of its members. As long as the consciences of men have remained dull enough to allow for the extirpation of their fellow men progress has been retarded.

C. Religious Fatalism

Further hindrances to a rational and humane treatment of the mentally ill have come from some of the absolutistic and fatalistic concepts found in our religious thinking. Despite the admonition that bids us to bear one another's burdens, the doctrine of sole individual responsibility in morals and in man's relation to deity repudiates social responsibility to such an extent that what happens to the individual becomes his problem, and his alone. Sin, that arch enemy of man, has always been something to be fought individually but, alas, not collectively. We are beginning to see that the individual's sin is the sin of us all. In the hinterland of our religious philosophies we still hold that a man's insanity is the consequence of his sin, and that the fierce suffering he experiences in his mental derangement is grim expiation for his personal wrongdoing.

D. Baneful Political Influence

Since mental and behavioral problems requiring institutionalization have, in the main, fallen to the state to solve it has been fairly easy for political influences to become dominant in their connection. Due to the isolated character of such institutions they have often been preeminently suited for political patronage, and have so been used. The outstanding objection to such patronage has always been that the job too often goes to some individual who is not competent and suited for the position. As long as custody instead of recovery and rehabilitation has been

the criterion of institutional management, stingy economy or even graft have often been the most attractive short cut solution, much to the discredit of the institutions.⁶ A lump sum budget in six or seven or more figures has often seemed very formidable to an appropriating legislator in the light of the fact that those for whom the appropriations were being made had no voting power, and indeed, were considered dead timber. Furthermore, the recipients of such appropriations seldom have a vocal alumni to plead the case of their brethen still in durance vile. Often not even relatives of patients have the sufficient courage or knowledge to make the needs of their sick kin known to proper hospital authorities or legislative bodies or in other ways to bring results. A hush thus established is one of the worst impediments to public enlightenment.

E. Antiquated Legal Procedures

Another delaying influence that has blocked quick and early attention that should be given mentally sick people has been the antiquated legal procedure still so prevalent in the commitment of patients to mental hospitals. It is a most common occurrence for mental patients to believe themselves punished and disgraced by the time they have been brought to a hospital. They are often taken into unexpected custody in their own homes by armed sheriffs, lodged in jail several days or weeks, taken before a judge, and finally whisked away under armed guard, and sometimes handcuffed, to a place where there are high stark walls, barred windows, locked doors, clanking keys, and where perchance a commanding, gruff attendant takes over. Present day thinking about commitment procedures finds an increasing number of mental experts and jurists subscribing to the opinion that a mentally sick person should be handled essentially like any other sick person without so many legalistic incumbrances and the punitive-like atmosphere. A few states have already tried

this more humane method successfully, and new proposed commitment laws generally embrace these principles. With the eventual elimination of the dichotomized thought that has for so long held a mental disturbance to be so vastly different in quality and prognostically from a physical illness, a more acceptable and rational approach will become possible in promulgating mental hygiene concepts at grass-root levels where they can do the most good.

F. Inadequate Medical Care

The extent to which mental hygiene problems still remain unattended can be drawn from the fact that, whereas, every one in a city, town, or hamlet has access to a physician who has been trained in the care of physical illness, there are still many communities which are entirely without some specialist who has been trained in the recognition and care of mental disturbances. It is true that many a general medical practitioner has acquired knowledge from his broad experience with patients that helps him in giving counsel to smooth a ruffled mind. Still, this is admittedly inadequate, for it is now believed that a fairly large proportion—some think as many as half—of all ailing people who come to a general physician have some form of mental disturbance underlying their ailment. A mere friendly pat on the shoulder, though sometimes very important, or a half hour session with an understanding doctor is not always sufficient to clear up the trouble, and the already over-worked doctor cannot always spare the necessary half hour or so for a leisurely searching interview.

IV. People Desiring to Know Their Mental Life

With our inadequacies in local facilities for handling mental problems there has developed an increased desire in people to know more about their mental life, and in particular, about

their disturbing mental experiences. A national news magazine recently reported that a nation-wide public library survey revealed that psychological material headed the list of subjects of interest to the reading public. This curiosity as well as serious interest of people is beginning to be met in many ways. Some of the largest class attendances in the psychology departments of our colleges and universities are in courses on abnormal psychology. Medical schools, of necessity, are increasing their psychiatric courses and training facilities. Anthropologists and sociologists are broadening their fields to include study of the relation of their particular interests to mental problems and mental welfare of social groups. Popular magazines of all kinds, movies, and newspapers have increased their volume of psychological writings and graphic portrayals. With this, however, has also come a marked growth in cultism, esoteric literature, and "schools" of all kinds which often claim to help the devotees to tap unheard of powers of the mind, and to attain material riches beyond their fondest dreams. One needs only to write to one or two such "schools" for preliminary information to find himself the recipient of solicitations from other similar helpers of the soul, and usually there is a small fee connected with the course that offers help to the inquiring one.

In addition to the informative help that has come to the public through the media of popular readings and visual materials, and through academic sources, the specific mental health organizations and agencies that have made it their purpose to aid have become quite numerous and diversified. Many public and private mental hospitals, although their essential functions have obviously been intramural, now operate out-patient departments, issue periodicals, and resort to public relation methods to lessen the fearsome aspects of mental illness. Mental hospitals, in particular state hospitals, have had a low sales value and a high degree of inversion. Only when such institutions will have reached the

respectability in their practice in the employment of trained and adequate number of personnel, and in their relation to the public which a general hospital usually enjoys will the misgivings about mental illness diminish. The initiative to bring this about and to further education in mental health has not always come from established hospitals.

V. Mental Health Organizations

A. The National Committee for Mental Hygiene, Inc.

The National Committee for Mental Hygiene Inc.,* originally founded by Mr. Beers after his unhappy experiences in mental hospitals, is today the outstanding organization in the United States in promoting mental health. It makes its influence felt through many different channels, and its support comes from lay as well as professional sources. Its stated functions are to give encouragement to other agencies having as their objective the furtherance of mental health, to sponsor and stimulate research in relation to mental illness and its treatment, to give communities, schools, churches, hospitals, and practitioners help in working out methods for handling mental problems. It provides fellowships for training in mental hygiene, furnishes health statistics, and arouses public interest in prevention and cure of mental illness. The Committee's official organ is a quarterly, *Mental Hygiene*, which is now in its thirty first year of publication, and its books, pamphlets, and free literature have gone to many foreign countries as well as to state mental hygiene societies for distribution to local organizations. Weekly radio programs and sound recordings of lectures on mental health have been added means used by the Committee for disseminating pertinent information.

B. The National Mental Health Foundation

In May, 1946, The National Mental Health Foundation* was

* Headquarters at 1790 Broadway, New York, N. Y.

* Headquarters at 1520 Race Street, Philadelphia, Pa.

founded. It is the outgrowth of the many experiences war objectors had throughout this country during World War II while working in various mental hospitals under the Civilian Public Service program. This Foundation likewise gains its support through membership funds and public contributions, and in turn lends its weight to plans for enlightenment and improved care of mental patients. One of the outstanding projects of the organization has been an extensive survey of mental health laws of various states, the findings of which have been put in form of briefs available to interested organizations and individuals. A sizable award, and several lesser ones are given annually by the Foundation to psychiatric aides in the United States for meritorious, outstanding service in mental hospitals. Its official publication comes as a quarterly bulletin, and in the same way that Mr. Beers' book became the spark of inspiration for the founding of The National Committee for Mental Hygiene so The Mental Health Foundation has derived some of its guiding purposes from the disturbing revelation of hospital conditions set forth in a book written by one of its members.⁷

Numerous privately endowed Foundations are in existence which work cooperatively with the just named national organizations, or have their own research and educational methods.

C. Professional Organizations

On the professional side the American Psychiatric Association, The American Medical Association, and the American Psychological Association are the main organized bodies to represent the interests of those whose chosen professional fields are in research, care, and treatment. The nursing profession is represented by the American Nurses Association.

Whereas these Associations provide over-all supervision, and work toward maintaining professional standards, many organizations have been set up in our more densely populated centers

to handle some of the first-hand conditions that often eventually lead to serious mental breakdowns. Many general hospitals now have psychiatric wards where special treatment is available, or where early diagnoses can be made. The Veterans Administration has assumed a greatly increased responsibility since World War II in the psychiatric care of recipients of veterans benefits, both in hospital and out-patient clinics. Social welfare agencies are giving more attention to mental hygiene problems through trained psychiatric social workers. Special psychiatric help and information can now be obtained from community and city clinics, although such organizations must of necessity usually operate on an out-patient basis. Child guidance clinics may now have facilities for handling mental problems, and with or without such facilities have increased their collaboration with juvenile courts toward implementing rehabilitation procedures. One of the outgrowths of this has been the establishment in various states of receiving homes for delinquents where systematic psychological diagnostic studies are conducted having proper placement of the young in mind. Public and private clinics now exist where the specific problems associated with marriage and divorce are given attention with some outstanding records of success. Very recently there has been a large increase of regular courses in marriage and family life in the curricula of high schools and colleges. Many colleges and universities now have counselors available to students for discussion of personal problems, and educative and guidance influence for better mental health are being more and more exerted at every level of school life.⁸

D. Alcoholics Anonymous

In 1934 an organization known as Alcoholics Anonymous*⁹ was started in Akron, Ohio by two men who had been tortured by alcoholic addiction. Today many cities and towns have per-

* The Alcoholic Foundation, Grand Central Annex Post Box 459, New York City 17, N. Y.

manent "AA" organizations whose purpose is to give moral and direct support to any alcoholic who has a sincere desire to rid himself of his compulsive drinking, and to educate against such drinking through their publications. In some mental hospitals the men and women of this organization work cooperatively with hospital authorities to reach alcoholic patients while they are in the hospital, and to give them supportive attention after they are released.

E. United States Public Health

Further final evidence of the extent to which the issues of mental health have begun to capture public attention can be seen in the educational activities of the United States Public Health Service through its Mental Hygiene Department, and in the recent establishment of the National Mental Health Authority which gives tangible as well as educative aid to mental health clinics, and encouragement to mental hospitals through the funds that have been made available by the Mental Health Act of 1946. Many states now have state mental hygiene societies, some of which have branch chapters in nearly every county, and have their own regular publications. Some of these state societies are still in a formative stage, lacking in telling effect, but with the influences that come from the better endowed and directed private and national organizations these state and local mental hygiene groups will represent the effective contacts for the betterment of the health of a community. In them one finds focused those local interests in mental welfare which the parent, the teacher, the preacher, the business man, and the general practitioner might entertain.

VI. Need For Further Research

After all we have done and said so far about the reduction of aberrant behavior in human beings we are still largely groping

in a pre-dawn darkness. We need greatly to increase our research in human conduct. Most of the research until now has been done in universities, in private mental institutions under special grants, and in a few of our larger and more progressive public hospitals. Most state hospitals have been sorely lacking in any research programs in spite of their excellent opportunities in this respect. It has been stated that we have a strong physics and a weak sociology. To this should be added, a weak psychology. The products of our rich research findings in the physical sciences have had a high saleability, a potential and real value for war, and an alluring tangibleness which, however, have disastrously outrun our meager knowledge of what to do with ourselves psychologically and socially. Research in human behavior follows two directions—an investigation of the psychological structure and function of the individual person, and secondly, a broadening of our knowledge of the social dynamics and physical environmental forces operating in the life of the individual. In a recent article¹⁰ Dr. Daniel Blain, Chief of the Neuropsychiatric Division of the Veterans Administration, enumerated a large number of questions about problems which still require a great deal of investigation and research—such questions as: what is known about occupational groups, different races, age groups, groups of various economic and intellectual levels in relation to mental health? What effect do various religious and political persuasions, or climatic conditions have on the mental health of people, and can there be national psychoses and neuroses? Are people markedly effected in their mental health by national and international trends, et cetera?

The information we have up to the present helps us to understand partly the genesis and the proximate causes of some of our mental disturbances, but we still do not have a sufficiently unified knowledge for the integration and control of our conducts at a level where certainty of mental health can have a

high degree of predictability. We can no more tolerate haphazardness in our mental life than we can permit it in a large business concern, or in the operation of a delicate complex machine, the corollary to this being that we cannot continue to permit it in our social structures upon which our emotional maturity and mental well being so intimately depend.

One of the most vulnerable areas in human society for the development of emotional and ideational distortions is our use of words. Here in itself still lies a vast field for research and reeducation. Semanticists,^{11 12} students of the meaning of words and other linguistic forms, point out that because words and other symbolic forms are only abstractions of reality their incorrect and incautious use causes us to lose sight of reality. Through the all-inclusiveness of the single name of a whole class of objects, which individually may differ a great deal among themselves, we often become so emotionally involved with a class of objects that we fail to do justice in our thinking and feeling to any single member of the class. That is, we invest a whole group of objects, coming under one abstract name, with the psychological reactions we have developed in our contacts with only one or two objects of the group. Thus it happens that we sometimes falsely say and believe that all Democrats, all Republicans, all negroes, Jews, Ford cars, Jersey cows, apple pies are good or are bad because we have had a few good or a few bad experiences with one or two segments of these broad classes. Such all-inclusiveness in our psychological investments lead us to lose sight of the broader inter-relationships of our experiences. It stifles tolerance and creativeness, and fixes our thoughts into absolutistic grooves from which escape sometimes becomes very difficult. Such fixity and narrowness of thought are among the most potent deterrents to happy healthy living. It could well be expected that the mental sanity of future generations would be greatly improved if we were to begin early enough in school

and church, public forum and the home to stress the specific realities that underly our knowledge and the meaning of our words. We would thereby forestall some of the confusions and the nerve-splitting tensions that come from our efforts to say "Yes" and "No" at the same time, or from our attempts to scrutinize the inscrutable, or seek happiness amid the inflexible absolutes that develop from some of our word babblings.

VII. Normal Outside World In Hospitals

It has been said that mental illness is the disease of civilization. It would follow from this that we correct those malfeasances that have been mistaken for civilization. It has been advocated that a mental hospital should reproduce as much as possible within the hospital the conditions of the normal outside world, so that when patients return to the routines of normal living they will be able to make the transition to the outside world more easily. It is undoubtedly meant that the hospital should emulate within its confines those practices and regimes of the world at large which enhance good living and creative activity. There are many conditions in the world, however, that could better be viewed as of such unhygienic quality that, in comparison, life in a mental hospital is sanity exemplified. A future program of mental hygiene which is to effectively touch mankind en masse may also take a lesson from some of the good things that happen to a mental patient in a hospital to make him well. Not a cell-like existence, not regimentation or a never-varying fare, or idleness, but the reduction of constant frustration and intense competition; the privilege of boldly saying "No" without loss of food and shelter; the opportunity to show one's self as he is without overwhelming inhibitions, and to state one's views, weird as they may seem, without violent contradiction and scorn. Under the incentives of rugged catch-as-catch-can individualism prodigious accomplishments have been possible, but

with the increasing complexity of life more and more people find themselves anachronistically done to a standstill through their individualistic strivings. The pioneer who had trees to fell before he could raise a crop found release of tension through the swing of his ax, and exhilaration in the anticipation of the fruits of his labor. But the man of today who, with the best of will and effort, finds his financial disbursements constantly out-running his income, and is faced with the alternative of a radical reduction in standards of living, is apt to wake up more tense than when he fell asleep.

VIII. Mental Hygiene A Potent Voice

In present day meetings of psychiatrists, educators, psychologists, and others interested in mental health issues, the discussions frequently lead to such problems as the threats of future warfare, inflationary conditions, insufficient housing, broken homes, racial and religious prejudices, and with this, then, usually comes the urgent plea for more trained personnel to care for mental patients. Evidently the greatest need is the elimination of those conditions which cause mental illness. A large army of mental experts would have its fullest justification in modern society only if its members could have a strong voice in the social engineering that will have to be progressively administered to maintain a sane world. Almost as soon as atomic scientists came into recognition in the struggle for the ascendancy of one nation over another they also quickly and boldly came forth with pronouncements that have given men pause for thought about mankind's continued inheritance of this earth. Likewise, men who busy themselves with problems of mental illness have come to be heard more, not mainly about the curious quirks of insane people, or how to give some friend advice, but about what must be done to repair those ruptures in our political, economic, and religious practices that have caused men to lose their bear-

ing. Men whose chosen professional interests are in the realm of mental welfare are well fitted to give testimony about what must be done to meliorate the things and conditions by which men live, for they know, from listening to endless heartbreaking stories, the dark byways and jungle tangles of man's daily living. They necessarily have acquired a large measure of reverence for life, for they know from their training and experience that all physical reality is subordinate to living.

It may be that mental hygiene programs and techniques as we know them now are only emergency steps in a critical transitional period of man's social evolution. It is conceivable, and possibly even desirable, that our mental hygiene movements should never become more than a potent voice in the wilderness, or provide some Savonarola preachments to point out abuses and a better way for the future, eventually, thereafter, then, to yield authority for the formation of a better society to broader, more universal civilizing influences. The term "mental hygiene" still has too much the atmosphere and connotation of a hospital about it. We do not hope for a society where preventatives and treatments need always be emphasized to the people. A neurotic society might result from the constant emphasis on health, with the possibility of illness repeatedly implied, as a child may grow into an ailing adult under the tutelage of fussy over-anxious, parents. Wholesome living would seem contingent upon the purposive organization in our behalf of the larger society of which we individually count ourselves a part. In the realm of mental health our emotional awareness of the part we play in a larger social field becomes of prime importance. Mere intellectual awareness of the correctness or incorrectness of behavior does not insure mental health. There must be the emotional warmth, and sense of security and maturity that come from the immediate recognition that the society which nurtures us is solid, kind and mature. Today, as it is, we feel disturbed despite our great

gains in pure knowledge. We intellectualize against war but we get it. We talk about the opportunities of modern life but we feel the blight of modern civilization. Too many of us still eye, like a hungry child at a bakery window, the marvelous products of scientific technology without hope that we shall ever actively and fully enjoy them. Langer¹³ states this in other words.

H. G. Wells referred to our time as the age of confusion. Flugel¹⁴ points out that the familial patterns of brother-against-brother and father-against-son aggressions and conflicts extend into our nationalistic and internationalistic strivings and conflicts. The divided loyalties and unresolved ideological clashes of which we hear so much now, whether of local or extended nature, bode poorly for our mental equanimity. To resolve some of our ambivalence, confusion, resistance, perplexity, we look for superauthorities or concepts that supersede and cut across the divisions that keep us in turmoil. In order that any superseding authority, of whatever nature, can give men a sense of equanimity and balance it must provide security without submerging the individual. This, of course, is the age-old problem in social evolution. Men have created a veritable hierarchy of extended authorities in which they could then extend their own egos, and gain release from the limitations of lesser domains of existence. The school, the club, the church, conferences, national and international assemblies, and finally an informal heartening brotherhood of understanding that comes from the emergence of science, have thus come into being

Improvement In Living

It has been argued, from the destructive use to which scientific knowledge has been put, that science has been made bankrupt through man's immorality. For our interest in mental health it may well be averred that, notwithstanding all our dislocations and travail, men never before have had such opportunity to

enjoy security and mental easement; such chances for personal expression, and release from interpersonal irritations as they now have through the application of scientific knowledge to their everyday living.

We lament that modern youths are getting soft and stunted because they have such little occasion to swing the ax or sweat it out by hard grubbing. The fact, however, seems to be that they have increased very perceptibly in average physical stature and strength over similar measurements of their elders of as little as one generation ago. This physical improvement from one generation to another has come as a surprise to many, but in retrospect has been attributed, among a number of things, to improved dietary practices that have kept apace with the general dictates of science. Despite our present great concern over the heavy load in our mental hospitals, it is quite conceivable that the general mental health of people is actually undergoing a basic improvement similar to what has been observed physically, but with less apparent dramatic speed, and for reasons we may not yet so clearly see. Unimportant as it may seem, a well marked and well constructed avenue is conducive to the mental ease and good behavior of both pedestrian and driver. Its orderliness is contagious, and it bespeaks a society that cares for its members. The switch on an electric washing machine has forestalled many a corrosive argument because Joe, who might have been planning a fishing trip, was spared the unpleasantness of helping with the family washing. Our more artistic and delightful use of color in plastics, clothes, automobiles, homes, street lights, and the thousands of other objects that daily meet our eye cannot but have a lifting effect on us to count life worth while. With all the jangling noise that modern contraptions can produce, the world has also become a world of music and drama at our mere beck to give us release from some of the drudgeries, frustrations, and somberness of our existence. Com-

monplace as some of these things are, and limited as they may be in reshaping some of the deeper layers of personality, they may be counted on to gradually change our mental complexion into less malignant forms.

And where scientific knowledge has been used for destructive purposes it has turned on us like a scolding taskmaster to teach us "morals," much as gravity bids us correct behavior near an unguarded cliff. Just now the discovery of fissionable material has given men a second and a third thought about their intentions—their morals, if we please. Their decision will have a profound bearing on their future mental health.

"The simple life" has often been advocated for surcease from our mental ills. We can have the simple life in our modern world, but through the intricate application of scientific technology in a way constantly commensurate with our differentiating society. The pathological crowding of human beings into great cities, where frictions and irritations and dislocations become intensified, is already being slowly corrected by decentralizing influences made possible through science. Too many people are still living in basement dwellings, or with an irritating mother-in-law, or in cottages which they will never own. This is still figuratively and actually in contradistinction to the ideal of the prophets of old who foresaw where every man shall sit "under his vine and under his fig tree, and none shall make them afraid." The mental well-being of the most ordinary home builder and voter is as much our concern as that of the master builder, the diplomat, and the legislator. A society operating on the principle of a thrown-together, fragmented mass of strong and weak individuals, with privileges of despotic overlordship, be it ever so refined, reserved for the strong, goes counter to the wisdom of the ages, and soon reflects itself in the mental fragmentation of its members—both the strong and the weak. As we continue to dedicate ourselves to the idea that all men are

created equal we will channel the recognized differences in the capacities and accomplishments of men into position of functional equality which is so essential to the healthy existence of human society as a whole, and to the personal integrity and well-being of even the least among us.

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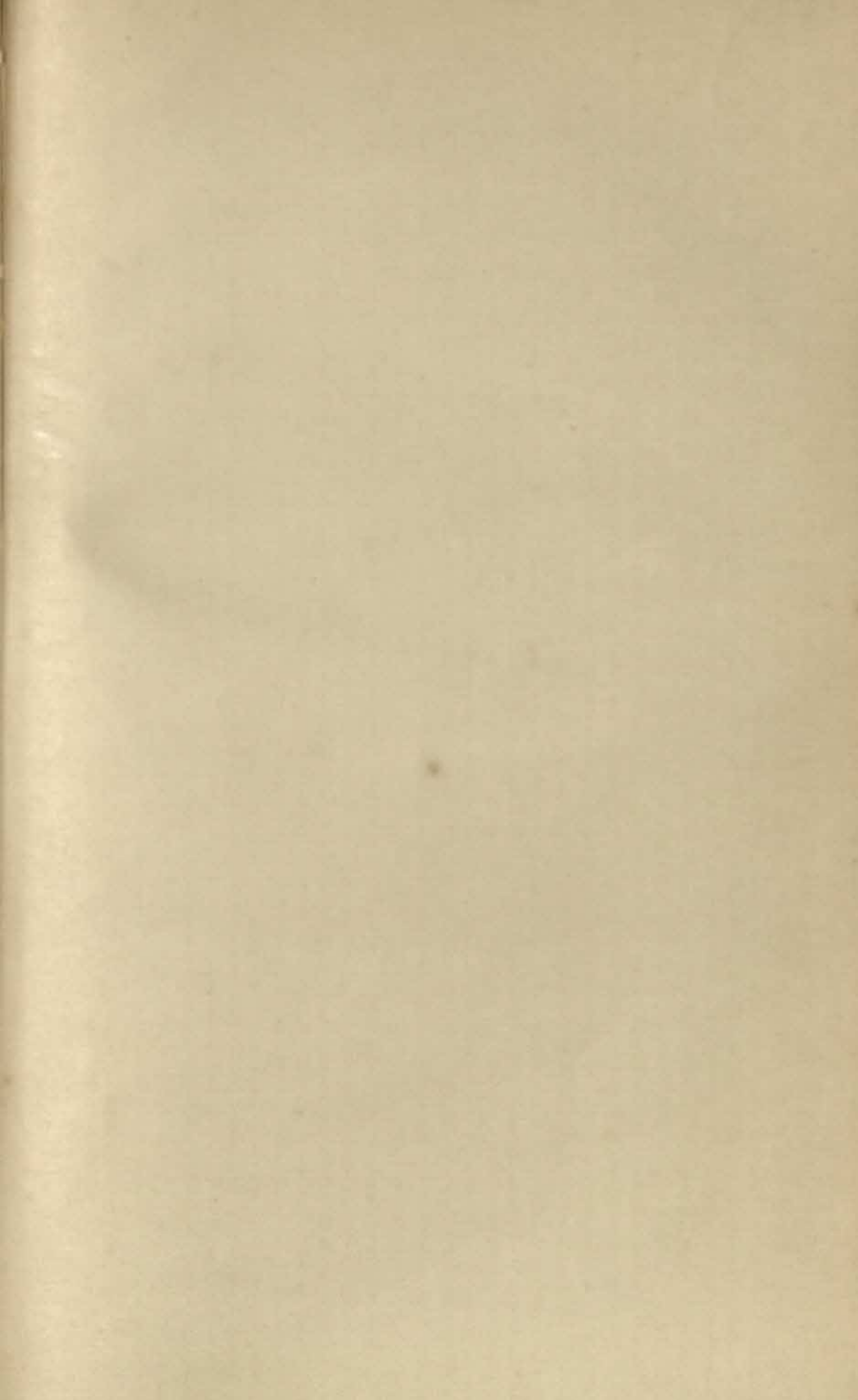
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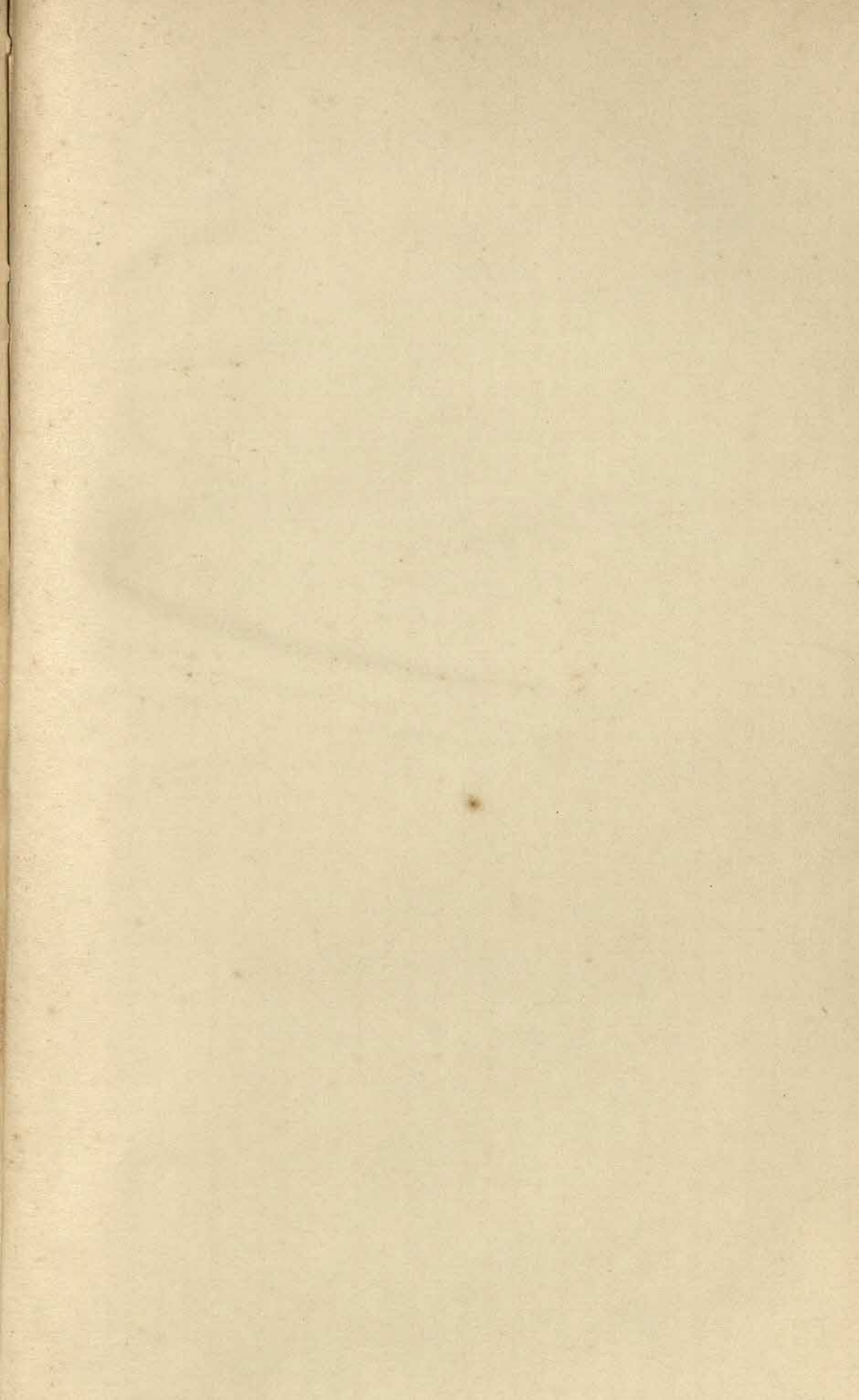
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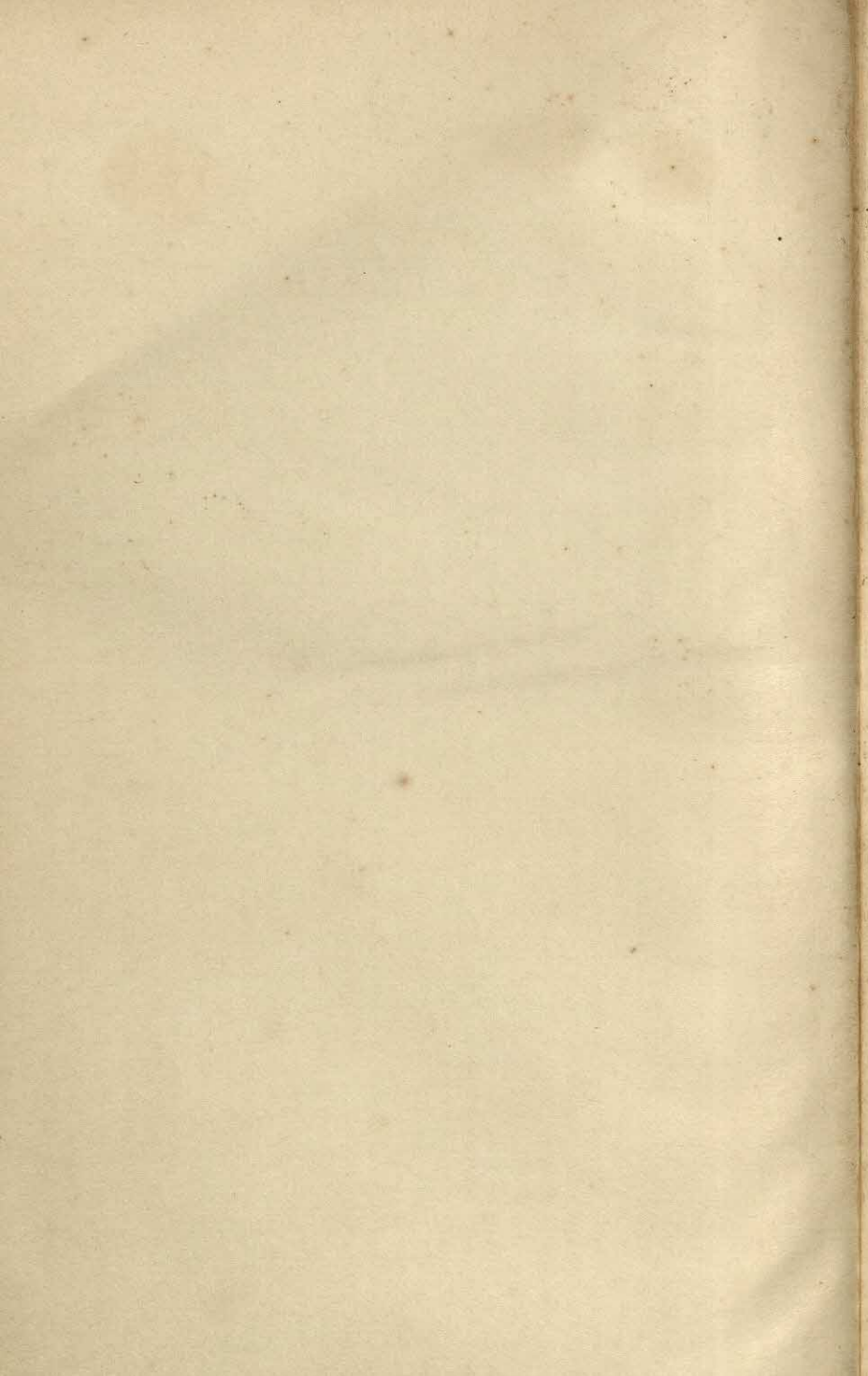
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